DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155684		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE: COMPL 07/15/2	ETED
NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE		p. wax	STREET A	ADDRESS, CITY, STATE, ZIP CODE IAMI CIRCLE I BEND, IN46614	1		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
F0000	Complaint # IN0 resulted in a Part Survey-Immedia  Complaint # IN0 Federal/State def allegations are ci F-226, and F-490 Survey dates: Jul Extended survey 2011  Facility number: Provider number AIM number:	te Jeopardy.  0093132-Substantiated, ficiencies related to the ted at F-223, F-225, 0.  y 11, 12, and 13, 2011 dates: July 14 and 15,  002662 : 155684 200315930 ni Krakowski, RN	F0	000	This plan of correction is submitted as required by law is not an admission of noncompliance; rather, it set as the facility's credible alleg of compliance.	rves	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6WFT11 Facility ID: 002662 If continuation sheet Page 1 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684		A. BUILDING	E CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/15/2011	
NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE			6450	ET ADDRESS, CITY, STATE, ZIP CODE  D MIAMI CIRCLE  JTH BEND, IN46614	1
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	findings cited in 16.2.	es also reflect state accordance with 410 IAC ompleted 7/20/11			
F0223 SS=K			F0223	Regarding Resident #B, CNA suspended on 5/4/11 after the fibecame aware of the allegation CNA was terminated on 5/9/20 following an investigation into matter. This incident was reported to 1/8/11.  Regarding Resident #C, CNA was terminated on 3/17/11, fol an investigation into this allegation into this allegation into this incident was reported to I on 3/14/11.  Regarding Resident #D, the fact has reviewed all grievances from	Pacility a. The D11 the orted to #18 lowing ation. SDH

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6WFT11 Facility ID:

002662

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155684 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6450 MIAMI CIRCLE SOUTHFIELD VILLAGE SOUTH BEND, IN46614 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CNA #3 on 7/4/11 that CNA #2 had resident and/or family members and the facility alleges that this allegation thrown her into bed and left her sideways was never reported to any member of in the bed. Resident # F then reported the administration at this facility. incident on 7/5/11 to the Director of Resident #D has since been Nursing who failed to suspend CNA #2 discharged from the facility. Because the facility was not aware of and protect other residents from potential these allegations during her harm during investigation of the alleged admission, an investigation into this abuse. The Administrator and the Director alleged incident did not occur. of Nursing (DON) were notified of the immediate jeopardy at 5:30 P.M. on Regarding Resident #F, the resident did not report to the facility that she 7/13/11. The immediate jeopardy was: had been thrown into bed. This removed on 7/15/11, but noncompliance allegation was not revealed to remained at the lower scope and severity administration until the ISDH of pattern, no actual harm with potential complaint surveyor interviewed the for more than minimal harm that is not resident. As soon as the facility became aware of this allegation, immediate jeopardy. CNA #2 was immediately suspended and an investigation was started. Residents: #B, #C, #D, #F, #G CNA #2 was terminated on 7/19/11. The surveyor was aware of this Findings include: incident during the survey, and a follow-up report was sent to ISDH informing them of the facility's 1. Review of a facility "Incident Report," conclusion to the investigation on dated 5/3/11, indicated, "...(Resident #B) 7/19/11. alleges that on Monday, 5-2-11, a CNA who gave her a shower treated her roughly Regarding Resident #G, CNA #8 was terminated on 5/9/11 and CNA #15 and had a "bad attitude." She reported was terminated on 7/12/11. that she was sprayed in the face with the shower sprayer...." Mandatory in-services began immediately upon the facility A"Resident/Family Concern Report," becoming aware of the immediate jeopardy citation on 7/13/11. All dated 5/3/11, and signed by the Chaplain, staff members were educated before indicated, "Nature of Concern: Resident the beginning of their next shift on: (#B) reported rough handling and bad the proper protocol to report abuse, attitude of CNA #8 when resident asked

Facility ID:

li ´		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ED
		155684	B. WIN			07/15/201	1
NAME OF I	DROLUBER OR GURRY IER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIER			6450 M	IIAMI CIRCLE		
	TIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re (	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,	1	DATE
	1 ^ *	d pan last week. Resident			what types of things to report, a what to do if the report is not	na	
		ad asked 'someone in			followed up on. Staff members	were	
	"	ve this CNA (#8) help			instructed to notify the	,,,,,,,,	
	with her care. La	ast evening, 5/2/11, (CNA			Administrator, or designee in the	ie	
	#8) came to do (I	Resident #B's) shower.			Administrator's absence,		
	(Resident #8) rep	oorted she was sprayed in			immediately upon becoming aw		
	the face, and (CN	NA #8) was not following			of any abuse allegation. In-serv	rices	
	her wishes conce	erning (Resident #B's)			for all staff were completed by		
	clothing"	,			7/18/11. (Attachment A)		
	<b>3</b>				Management and on-call nursin	σ	
	   During interview	with the DON on			staff were in-serviced on 7/14/1		
	_	2.M., she indicated she			review proper protocol for repo	rting	
		sident #B requested CNA			abuse. (Included in Attachment	(t A)	
		•					
	#8 not be assigne	ed to provide her care.			The facility Administrator revie		
					the facility's policies and proce	dures	
		n" report, dated 5/4/11			regarding abuse and neglect on 7/13/11. They were found to be	,	
	"	N #9, indicated, "On			reasonable and accurate. Howe		
	Monday, May 2n	id, approx			after further review, minor	, 61,	
	(approximately)	9:00 P.M., I entered			modifications were made to the		
	(Resident #B's) (	room number) with her			policy, "Abuse- Identification of	of and	
	H.S. (bedtime) m	neds (medications).			Protection of the Resident" to		
	(CNA #8) had jus	st showered her.			simplify the language and the		
	(Resident #B) sai	id to me: 'I don't know			procedure for staff members.  (Attachment B)		
	l ` ′	ith that girl. I don't like			(Attachment D)		
		lles me. When I saw her			The facility Medical Director w	as	
	1 *	s in for it'The previous			notified of the immediate jeopa		
		N #10) had called			citation on 7/14/11.		
	`	: (regarding) a conflict					
		nt #B) and (CNA #8).			The phone numbers of the		
	`	, , , , , , , , , , , , , , , , , , , ,			Administrator and Director of		
	1 '	d not want (CNA #8) in			Nursing were posted in multiple locations on 7/14/11 in order fo		
		working Wing 200 that			staff member to directly notify	ı any	
	` ′	erheard the phone			administration of any allegation	is of	
		he nurses station on			abuse, at any time.		
	Wed., April 27th	."					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155684		(X2) MU A. BUII B. WING	LDING	NSTRUCTION  00	(X3) DATE COMPI 07/15/2	ETED
NAME OF PROVIDER OR SUPPLIER SOUTHFIELD VILLAGE			•	6450 MI	DDRESS, CITY, STATE, ZIP CODE IAMI CIRCLE BEND, IN46614		
(X4) ID PREFIX TAG	Review of the "C Assignment," da CNA #8 had bee #B's) room.	ted 5/2/11, indicated n assigned to (Resident		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  The form used as a guide for discussion in daily stand-up me was revised on 7/14/11 to inclu- statement, "Allegations of abus neglect?" (Attachment C)  In order to ensure all staff are	eeting ide the	(X5) COMPLETION DATE
	7/11/11 at 3:20 F documentation or counseling, or diregarding the iss regarding Reside alleged rough has assisting her with An "Employee C 5/3/11, indicated 5/3/11 pending in indicated in the indicated in the indicated in the indicated on 5/4 Resident #B's clareviewed on 7/11 indicated diagnor congestive heart (high blood presson osteoporosis (abidensity). An initiation Set) Assessment	f an investigation, sciplinary action ue reported by LPN #10 ent #B's accusation of indling by CNA #8 when in the bedpan (4/27/11).  Counseling Form," dated CNA #8 was suspended investigation. The DON interview on 7/12/11 at investigation in 1/12/11 at investigation in 1/12/11 at investigation in 1/12/11 a			educated on abuse and neglect ongoing basis, the facility will continue to provide education of subject upon hire and at least to annually.  In order to monitor and ensure abuse policies are followed, the Administrator or her designee, randomly interview five reside week for a time period of no let than six months as to how staff members have been treating the Any concerns will be thorough investigated. (Attachment D)  Results of the monitoring progwill be reviewed at the monthly (Continuous Quality Improvem meeting. Areas of non-complia will be addressed immediately.  Alleged date of compliance is 7/18/2011.	on this vice that e will ints per ss em. ly ram y CQI inent) ance	
		clinical record was					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  STREET ADDRESS, CITY, STATE, ZIP CODE	
B. WING	11
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
6450 MIAMI CIRCLE	
SOUTHFIELD VILLAGE SOUTH BEND, IN46614	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
THE REGULATORY OF ESCHIEFATH THE INCOMPLETENCY THE	DATE
reviewed on 7/11/11 at 11:55 P.M. and	
indicated diagnoses of, but not limited to,	
osteoporosis, rheumatoid arthritis, and	
fractured left femur (thigh bone).	
Resident #C's initial MDS (minimum	
Data Set) Assessment, dated 3/17/11,	
indicated she was cognitively intact with a	
score of 15 out of 15.	
Review of an "Incident Report," dated	
3/14/11, indicated, "(Resident #C) told	
this writer today at 3:00 P.M. about a	
problem that she had on Saturday,	
3/12/11. She states that (CNA #18) on	
Saturday 'went all crazy. She started	
pulling my bed and moving stuff around.	
She was loud and had me so upset I	
couldn't half talk. She was swinging my	
leg around so fast.' I asked if anyone had	
hurt her or yelled at her. She said no, but she was scared"	
SHE Was Scared	
A "Resident Statement," dated 3/14/11,	
was the result of a conversation with the	
DON and indicated, "You know I don't	
know what she (CNA #18) went crazy	
about. The other lady (CNA #2) looked	
like she was scared of her. She was	
movin stuff around, the bed was facing	
the closet. I said, 'I can't have that way.'	
She had me so upset I couldn't half talk.	
Someway I got to the phone and called my	
daughterShe (CNA #18) was swinging	
my leg around so fast, tooI been having	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  COMI	
AFECOA R. BUILDING O7/45	PLETED
155684 B. WING 07/15/	2011
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
6450 MIAMI CIRCLE	
SOUTHFIELD VILLAGE SOUTH BEND, IN46614	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
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THE REGULTION OF ESCHEDING THE ORGANIZATION	DATE
so much pain in that leg"	
During interview with Resident #C on	
7/12/11 at 9:20 A.M., she indicated, "I	
needed to go to the bathroom. Two	
CNA's came in to assist me when the one	
girl (CNA #18) went crazy because she	
needed more room to get me on the	
commode (bedside). I was so frightened I	
couldn't talk and I was having trouble	
breathing. A third girl came into the	
room. At one point, they all went into my	
bathroom and closed the door. I don't	
know what they were talking about in	
there. When they got me back into bed, I	
was facing the wall. I didn't want to face	
the wall, I wanted to be able to see out my	
window. The one girl (CNA #18) was	
slamming things around and shouting. I	
didn't know what she was going to do	
next. I was so scared of her. I managed	
to call my daughter to tell her, but it so	
happened my son was coming to visit. He	
said he could hear me calling for help all	
the way down the hall."	
During a telephone interview with CNA	
#2, the other CNA in the room, at the time	
of the incident, indicated CNA #18 was	
assigned to Resident #C on the day of the	
incident, but she (CNA #2) took care of	
her all day "because I knew how (CNA#	
18) could be. I knew (CNA #18) was a	
very forward type of person and that back	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				ONSTRUCTION  00	(X3) DATE : COMPL		
111,12 12,111	or confidence.	155684		LDING		07/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1	IAMI CIRCLE		
SOUTHF	FIELD VILLAGE			1	I BEND, IN46614		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG	+		-	IAG	Dia relative 17		DATE
	1	heavy and she's (CNA					
	1 '	y." She further indicated					
	1 -	nt #C they would have to around and she was					
		o what ever you need to					
		•					
		C threw her arms up in					
	1	te she was praying. I needed her oxygen					
	1						
	When queried if	yay she was acting."					
	1 *						
	1	NA #2 stated, "I felt that ng excessively. She					
	1	•					
	1	lained things first. (CNA					
	1	usive in any way (but) she					
	1	a drill sergeant. Some					
	residents though	t she was a man."					
	The DON indica	ated in an interview on					
	7/11/11 at 1:30 I	P.M., she didn't feel she					
	could substantia	te that abuse took place,					
	but felt since she	e had other issues with					
	both of the CNA	's (#2 and #18) "It					
	warranted termin	nation."					
		nical record of Resident					
	#D was reviewed	d on 7/12/11 at 10:45					
	A.M. and indica	ted diagnoses of, but not					
	limited to, vertel	oral compression fracture,					
	1	ration (progressive					
		the eye which leads to					
	blindness), perip	heral vascular disease					
	(restricted blood	flow), fractured left hip,					
	and spinal steno	sis (narrowing of the					
	vertebrae). Resi	dent #D's initial MDS					

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<b>l</b> i ´		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155684	B. WING		07/15/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
COLITUE				MAMI CIRCLE	
	TIELD VILLAGE		50011	H BEND, IN46614	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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IAG		· · · · · · · · · · · · · · · · · · ·	IAG		DATE
	`	Set) Assessment, dated			
	· ·	d she was cognitively			
	intact with a scoi	re of 15 out of 15.			
	During intervious	with Resident #D's			
		/11 at 2:15 P.M., she			
	•	ther had told her that a			
		ed at her, threw her in			
	-	"I'm tired of you using			
	1	nt. I'm tired of coming			
	_	'My mother complained			
	I -	me. They're mean to me.'			
	I, at first, though	•			
	' '	•			
		when the bruises and			
		dent, I went to the DON			
	<u> </u>	s. I told her mother			
		JA as being (race stated),			
		DON said, 'We don't			
	`	stated) girl working here.'			
	*	ying in bed and looking			
	her look tall."	ual which probably made			
	ner look tall.				
	In a second inter	view with Resident #D's			
		/11 at 9:20 A.M., she			
	•	ted her mother if she			
		the name of the CNA			
	· ·	with her. "It was a (race			
	, -	e middle of the night."			
	·	in to the DON (Name)			
		ent. We were very upset			
		were discovered at the			
	_	remembers them shoving			
	her around and si	lamming her into bed and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684			(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	ľ	e survey pleted /2011
	PROVIDER OR SUPPLIER		STREET A 6450 M	ADDRESS, CITY, STATE, ZIP CO IAMI CIRCLE I BEND, IN46614	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	she told them, 'B break my hip, ag	e careful your going to ain.' "				
	7/12/11 at 10:35 was able to valid the CNA was just indicated, as a rethere was a need.  The Nursing staff and indicated CN stated) CNA who Resident #D on the and June, 2011 staff was assigned Resident #D on the 5/31, 6/7, 6/14, 6/13/11 at 5:50 Aresidents frequent about a particular resident. "I overhrude to a resident resident, 'I can't the again. You just with Three or four of nurse's, but nothing about it."	with the DON on A.M., she indicated she ate with the resident that thurrying. She further sult, she did not feel to do a State Reportable.  If schedule was reviewed to the night shift. The May chedules indicated CNA do to provide care to the following dates: 5/24, 1/18, and 6/19/11.  If with CNA #14 on A.M., she indicated the complained to her the CNA refusing to toilet a meard (CNA #15) being the the take you to the bathroom went 10 minutes ago.' The complained to the take gone to the sing seems to be done				
	5/13/11 at 5:45 A	ed in an interview on A.M., "One night (CNA and told me she was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155684		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE			p. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  AMI CIRCLE BEND, IN46614		
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	tired of answerin light and I would #15) said, 'She's When queried if Supervisor she st about it with the During interview 7/13/11 at 5:50 A resident complain left in bed. CNA to the bathroom with the wasn't soile when I took her.'  4. Resident #F's a reviewed on 7/13 indicated diagnost depression, osteol lumbar stenosis (wertebrae in the state of the state	g (Resident #G's) call have to do it. (CNA getting on my nerves.' " she reported it to the tated, "No, but I talked other nurse."  with CNA #17 on a.M., she indicated a ned to her that she was #15 would not take her when she needed to go. d, but she really gushed  clinical record was 3/11 at 4:00 P.M. and ses of, but not limited to, parthritis, and severe for a record of the		IAU			DAIL

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				NSTRUCTION 00	(X3) DATE : COMPL		
l   155684   l			A. BUIL		<del></del>	07/15/2	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				IAMI CIRCLE		
SOUTHF	FIELD VILLAGE				BEND, IN46614		
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TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
		identified as alert and					
		n, place, and time by her					
	1 * *	story and Physical 4/11, and by Social					
	_						
		during an interview on P.M. Resident #F's 14					
	day MDS (Minir						
	,	ed 6/17/11, indicted she					
		intact. She was admitted					
	, ,						
	hospital.	6/7/11 from an acute					
	nospitai.						
	During interview	with Resident #F on					
		A.M., she indicated that					
		go, CNA #2 came into her					
	·	r to the bathroom. CNA					
		tting Resident #F's					
	1	hile she was sitting down.					
		CNA #2 that Physical					
		her she should be					
	1 ^	e brace is put on her.					
		ed, "I'll do it my way."					
	1 ^	er put the brace on while					
		ne was desperate to get to					
	ı ~	hen she finished in the					
		#2 assisted her to her bed.					
		in, confronted CNA #2,					
		ng the position of the side					
	1	Resident #F informed					
	CNA #2 that Phy	sical Therapist #6 taught					
	· -	d with the side rail down					
	so she could posi	tion her body up higher					
	on the mattress.	CNA #2 replied in a					
	snotty manner, "	I'm not the therapist."					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBI	ER:	MULTIPLE CO	NSTRUCTION 00		COMPLE	TED
		155684	B. W				07/15/20	11
NAME OF I	PROVIDER OR SUPPLIE	R		I	DDRESS, CITY, STA	TE, ZIP CODE		
COLUTIVE					AMI CIRCLE	4		
	FIELD VILLAGE			SOUTH	BEND, IN46614	4		
(X4) ID		STATEMENT OF DEFICIEN		ID		LAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED		PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIATE TCIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFOR		TAG	DEF	RELENCTY		DATE
		icated she was sitting	~ I					
		ed when CNA #2 gr						
	1 -	e and pulled her dow						
		of the bed. "She then						
	1 -	lders down on the b						
		from my w/c onto						
	_	sheet I used to cov	•					
	_	there. When she got						
	_	ed as an apple. I was						
	1 -	would get injured. I	٠					
	1	I don't want to have	-					
		pain for nothing. I'm	ı just					
	beginning to rec	over." Resident #F						
	indicated she co	uld not get anyone t	o help					
	her, but when sh	ne saw CNA #3 outs	ide					
	her room she wa	eved to her and she	came					
	to offer assistant	ce. "She said, Oh de	ear,					
	what happened t	to you? I told her wh	nat					
	CNA #2 had dor	ne to me." Resident	#F					
	indicated CNA #	#3 had a physical						
	condition which	restricted her ability	y to					
	lift, but together	they managed to ge	et her					
	up in the bed. "S	She rescued me." Wl	nen					
	queried about th	e incident and what						
	Resident #F was	s feeling at the time,	she					
	indicated she wa	as fearful of CNA #2	2.					
	.Resident #F ind	licated CNA #2 no le	onger					
	provided her car	e, "I feel better that	she					
	isn't near me, bu	t I would feel better	ifI					
	didn't have to se	e her." Resident #F						
	indicated she tol	d the Director of Nu	ırsing					
		day about CNA #2	~ I					
		ghtened her. She ind						
	_	ocked and stated sh	l l					
FORM CMS-2	2567(02-99) Previous Versi		Event ID: 6WFT	11 Facility I	D: 002662	If continuation she	et Page	======================================

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155684	A. BUI		00	07/15/2	
		100004	B. WIN		DDDEGG CITY CTATE ZID CODE	0771072	011
NAME OF	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
SOUTH	FIELD VILLAGE			1	BEND, IN46614		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NCED TO THE APPROPRIATE	
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	roblems with CNA #2 in					
	1 ^	ld me CNA #2 would not					
		ke care of me again." She					
	1	the DON told her if she					
	_	re could be legal					
	ramifications as	a result.					
	The DON indica	ted in an interview on					
	7/13/11 at 11:00	A.M. that she had not					
	suspended CNA	#2 because Resident #F					
	did not mention to her that CNA #2 threw						
	her into bed, but that she was bossy and						
	put her into the b	ped and left her feet					
	hanging off the b	ped. "Forty-five minutes					
	later, when I sou	ght clarification, Resident					
	#F told me her fo	eet were on the bed and					
	she used her foo	t to get her call light."					
	1	er indicated CNA #2 was					
	one of her best v						
	1	iew with the DON on					
	7/13/11 at 2:30 I	P.M., evidence of an					
	1	the incident between					
	Resident #F and	CNA #2 on 7/4/11 was					
	requested from t	he DON. The DON					
	indicated she wo	ould retrieve it from her					
	office but, just m	ninutes later, the DON					
	was observed in	terviewing LPN #7					
	1	eident that had been					
	reported 8 days i	previously (7/5/11). The					
	1 -	he had not written up an					
	1	hen queried if she could					
	1	he report, she produced a					
	1 ^	IA #2, dated 7/5/11, in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		A. BUII	LDING	NSTRUCTION  00	(X3) DATE: COMPL 07/15/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  AMI CIRCLE BEND, IN46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	story of the incid statement, CNA wanted to go to the bed, but she informurse would like recliner. "She to side rail. I told how we transfer could grab it. I hand lifted her leg at me for not putt and asked to see indicated she we two or three time wanted to see her busy. The DON at 2:45 P.M., wri Resident #F proving a telephor 7/13/11 at 2:50 Printle presence of "speaker phone" she found Reside bed. She further it told her CNA #2 left her there." Control of the country to the incide to the country to report the incide to the country to the	d a completely different ent. In her written #2 indicated Resident #F he bathroom and get into rmed the resident that the her to sit up in the ld me to put down the er to let me show her with the rail up, so she helped he (sic) into bed into bed. She got mad ting down the side rail the nurse." CNA #2 ht to LPN #7 and told her es that Resident #F r, but LPN #7 was too was observed on 7/13/11 ting the statement rided her on 7/5/11, but be bed been and of an investigation. The conversation on the end of the down and with the on, CNA #3 indicated ent #F sideways in her indicated Resident #F "threw her into bed and NA #3 and LPN #7 failed dent to the DON, but voiced mistreatment to					

002662

A. BUILDING	IPLETED
155684 07/15	s/2011 I
B. WING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6450 MIAMI CIRCLE	
SOUTHFIELD VILLAGE SOUTH BEND, IN46614	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
5. During interview with Resident #G on	
7/13/11 at 10:35 A.M., she indicated she	
was fearful of using her call light because	
she had been yelled at by a staff person	
for having to go to the bathroom so much.	
"She would get angry when I had to go the	
bathroom. She was yelling 'Ever since	
they removed the catheter you've been a	
problem.' When someone knocks, I jump.	
I told them I was sorry, but I couldn't help	
it. Every time this need comes up (to use	
the bathroom) I get frightened. Recently, I	
had my light on, but no one came. I hurt	
because the pressure was so great. I took	
my blanket and folded it into a square	
and tucked it under me so I could pee on	
it without getting the rest of my bed wet.	
I reported that to (Social Service Staff #5)	
and the DON.	
Social Service Staff #5 indicated in an	
interview on 7/13/11 at 12:00 P.M. that he	
had been made aware of the situation and	
he met with Resident #G to discuss her	
feelings. He indicated this latest incident	
with the lack of a call light being	
answered happened on Monday, 7/11/11.	
"Resident #G has impaired vision and she	
was uncertain of the time, but she	
believed it was early morning around 5:00	
A.M."	
During interview with the DON on	
7/13/11 at 5:00 P.M., regarding the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155684	B. WINC			07/15/2	011
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
COLITHE					IAMI CIRCLE I BEND, IN46614		
	TIELD VILLAGE				I BEIND, IN40014		
(X4) ID		TATEMENT OF DEFICIENCIES	l ,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
mo		by Resident #G during	•	1110			DITTE
	_	er on 7/13/11, she					
		still investigating the call					
	light issue.	atin investigating the can					
	light issue.						
	   Review of an "Ir	iternal Investigation"					
		5/11, it indicated, "Date					
	of Occurrence:						
	Saturday night.						
	Occurrence: (Re	*					
	(complained of)						
	_	she wants to go to the					
		nd that her hands hurt					
		I her by the hands to take					
		room" A "Resident					
		t, dated 4/4/11, indicated,					
	1	ve vision and I can seeI					
		ng the night or late					
		all about me having to go					
	_	This person was saying					
		to the bathroom all of the					
	_	a time when I was. She					
		lem. She was angry kind					
	1	need to do something					
		nds are tender and she					
		ands to take into the					
	bathroom. They						
	<u> </u>						
	A written statem	ent by RN # 11, undated,					
	indicated, "At 12	2 A (12:00 A.M.) 4/3/11,					
	(Resident #G) be	egan to tell me of an					
	incident that she	said happened last night.					
	Attempted to cla	rify the time frame, but					
	she was unsure.	I gathered enough					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155684	A. BUI			07/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				IAMI CIRCLE		
SOUTHF	TIELD VILLAGE			1	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	-	IAG	DEFICIENCE (		DATE
		all in the morning to on 7:45 A. MWhen I					
		(Supervisor), she called					
	l '	d requested a full					
	` ′	dy check. Resident					
		t happened as it occurred.					
		dn't remember putting on					
	` ′	neone came in, (Resident					
	•	at her. The following are					
	statement conten	C					
		go (urinate) more than					
		Resident (#G) said she					
	*	he bathroom. "I know					
		going pee"Someone					
		ls and was rough moving					
	-	u need to do something					
		er. You need to get your					
	*	There is something					
		' Resident (#G) replied,					
	"	e. (Resident #G) used					
	1	il.' The person kept					
		ut the event to the					
	"	ck. (Resident #G) said					
		and she was shaking all					
	· ·	er hands hurt when they					
	grabbed them"	-					
	The "Internal Inv	estigation" further					
		nt G's son made the					
		ik this story about					
		ining about her going to					
	_	ot comes from when she					
		know she is really					
		comes to her arms and					
					1		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155684	A. BUILDING	00	07/15/2011
		100004	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0771072011
NAME OF F	PROVIDER OR SUPPLIER			MAMI CIRCLE	
	IELD VILLAGE		I	H BEND, IN46614	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		t "Conclusion: (Resident	IAU		DATE
	_	confusion. Statements			
	from staff are pro				
	•	son seems to think that			
	she is repeating a				
	sile is repeating t	in ord raca			
	A "Resident/Fam	nily Concern Report,"			
	dated 4/18/11 and	d signed by the DON,			
	indicated, "Cond	cerning Resident #G			
	Nature of Concer	rn: This writer noted			
	resident coming	down the hall in her			
	wheelchair being	g pushed by (CNA #13), I			
	asked (Resident a	#G) how she was doing.			
	She said, 'Not ve	ry good right now.' Upon			
	further questioning	ng she complained that			
	one of the CNA's	s complained that she was			
	'peeing' too much	nI questioned (CNA			
	· · ·	IA in her room this			
	afternoon. (CNA	A#8) said 'I didn't say			
	that, I just took h	er to the bathroom."			
	•	A (#8) that resident's			
	many times have				
	1 2	fferent reasons and that			
	, ,	is. We merely take them			
	to the bathroom				
	-	CNA apologized to			
	resident.				
	A lotter to the Inc	diana State Department of			
		111, which included the			
	· ·	regarding CNA #8 and			
		on by Resident #B)			
		NA #8) was also involved			
	, ,	omplaint made by			
	011 <del>1</del> /10/11 111 d C	ompianit made by			

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURV	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETE	D
		155684	B. WIN			07/15/2011	
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIER			6450 M	IAMI CIRCLE		
	TIELD VILLAGE				I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re CC	OMPLETION
TAG			-	TAG	DETICIENC!)		DATE
	· ·	(Resident #G). She					
		o CNA's complained that					
		frequently. One of these					
	CNA's was (CNA #8)"						
	Review of Resident #G's clinical record						
		2:00 A.M., indicated					
	diagnoses of, but						
	"	miparesis, and legally					
	••	idmitted to the facility on					
		cute hospital. A quarterly					
		Data Set) Assessment,					
	`	dicated Resident #G's					
	I						
		ely impaired, was					
	*	ontinent of urine and					
		ssistance of one for					
	toileting.						
	During interview	v with CNA #14 on					
	5/13/11 at 5:50 A	A.M., she indicated					
		itly complain to her about					
	1	refusing to toilet a					
	1 *	neard (CNA #15) being					
		t. I heard her tell the					
		ake you to the bathroom					
	1	went 10 minutes ago.'					
	-	us girls have gone to the					
		ng seems to be done					
	about it."	ing seems to be done					
	1 about 1t.						
	LPN #16 indicate	ed in an interview on					
	5/13/11 at 5:45 A	A.M., "One night (CNA					
	#15) came to me	and told me she was					
	l '	g (Resident #G's) call					
		<u> </u>			l		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or conduction	155684		LDING	00	07/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	IAMI CIRCLE		
SOUTHF	IELD VILLAGE			1	BEND, IN46614		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	~	have to do it. (CNA					
	· · · · · · · · · · · · · · · · · · ·	getting on my nerves.' "					
		she reported it to the					
	_	ated, "No, but I talked					
	about it with the	other nurse."					
		14 OLA #15					
	~	with CNA #17 on					
		A.M., she indicated a					
	•	ned to her that she was					
		#15 would not take her					
		when she needed to go.					
		d, but she really gushed					
	when I took her.'	'					
	Pavian of a facil	lity policy titled "Primary					
		n Policy," dated 9/2000,					
	l .	y: It shall be the policy					
		lage that all residents of					
	l -	ree from verbal, sexual,					
	1 * *	ntal abuse, corporal					
	punishment and						
	l	y/Procedure Definitions:					
		villful infliction of injury,					
		nfinement, intimidation,					
	_	ith resulting physical					
	_	ental anguish. Also					
	_	ation by an individual,					
		aker, of goods or services					
	l .	y to attain or maintain					
		and psycho-social well					
	"	Abuse: The use of oral,					
		ed language that willfully					
		ging and derogatory terms					
	to resident or the	ir families, or within					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING D. WING			(X3) DATE COMPI 07/15/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  AMI CIRCLE	1 017 101	
5001HF	TIELD VILLAGE			SOUTH	BEND, IN46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	threats of harm, so resident4. Physhitting, slapping, also includes concorporal punishman Includes, but is in humiliation, hara punishment of defailure to provide necessary to avoid anguish, or mentillnessAbuse-IdofProcedure: 1 personnel will be potential for abuse Administrator with monitoring qualitimprovement propatterns, occurred would be suggesswithin the facility will be responsible incident/accident abuseInvestigation. It facility to finalized 3-5 days"	eprivationNeglect: e goods and services id physical harm, mental al dentificationstaff and supervisory e cognizant of the se of residents2. The ill be responsible for ty assurance and quality egress reports for nces and trends that tive of abuse, neglect, ity. 3. The Administrator ele for monitoring reports for potential tionProcedure:3. hich involve abuse, restigated as follows: 3.1					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/15/2011		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
SOUTHF	IELD VILLAGE			SOUTH	BEND, IN46614			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLA! (EACH CORRECTIVE A CROSS-REFERENCED DEFICII	TO THE APPROPRIATE	<u> </u>	(X5) COMPLETION DATE
IAG	7/5/11 was remo facility suspende alleged abuse and began immediate on proper protoc abuse and neglect abuse policy and to be reasonable all management staff to review properties abuse, revised the form to include a neglect, notified Director of the irreposted phone numerated phone num	ved on 7/15/11 when the d the staff accused of d began investigations, a mandatory in-services ols to follow regarding et, reviewed facility's procedure and found it and accurate, met with staff and on-call nursing rotocol for reporting e daily stand-up meeting allegations of abuse and the facility Medical mmediate jeopardy,		IAG	DEFICI			DATE
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	6WFT11	Facility I	D: 002662	If continuation she	eet Pa	ge 23 of 74

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155684			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/15/2011
	ROVIDER OR SUPPLIER		STREET. 6450 M	ADDRESS, CITY, STATE, ZIP CODE  MIAMI CIRCLE  H BEND, IN46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This Federal tag 00093132.	relates to complaint IN			
	3.1-27(a)(1) 3-1.27(b)				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155684	B. WING		07/15/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L	<b>I</b>	MAMI CIRCLE	
SOUTHF	TIELD VILLAGE		l l	H BEND, IN46614	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=L	have been found of or mistreating resistance had a finding nurse aide registry mistreatment of resistance of their property; a has of actions by a employee, which we have a soften to the control of the	not employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State concerning abuse, neglect, esidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for			
		e aide or other facility staff to de registry or licensing			
	violations involving abuse, including ir and misappropriat reported immediate the facility and to with State law through	ensure that all alleged g mistreatment, neglect, or njuries of unknown source cion of resident property are tely to the administrator of other officials in accordance ough established procedures tate survey and certification			
	alleged violations	nave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the ad representative and accordance with S State survey and o working days of th	nvestigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 to incident, and if the alleged d appropriate corrective sen.			
	Based on interview	ew and record review, the	F0225	F 225	07/18/2011
	facility failed to physical and verl to State authoriti	ensure allegations of bal abuse were reported es as required, and in the facility's policy for 2		Regarding Resident #B, CNA # suspended on 5/4/11 after the fa became aware of the allegation CNA was terminated on 5/9/20	acility . The

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			COM			(X3) DATE SURVEY  COMPLETED
THINDTENH	or conduction	155684		LDING		07/15/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0.7.10.20.11
NAME OF I	PROVIDER OR SUPPLIER			1	IAMI CIRCLE	
SOUTHF	IELD VILLAGE		SOUTH BEND, IN46614			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		
	` `	esidents: #B, #D)			following an investigation into matter. This incident was report	
		se in the sample of 4 and			ISDH on 5/3/11.	ited to
	· `	Residents: #F, #G) in the			19911 011 3/3/11.	
	supplemental san	nple of 6.			Regarding Resident #D, the fac	ility
					has reviewed all grievances from	
	The immediate jeopardy began on 7/05/11				resident and/or family members	
		F, who was recovering			the facility alleges that this alle was never reported to any mem	
	from recent back surgery, reported to CNA #3 on 7/4/11 that CNA #2 had thrown her into bed and left her sideways in the bed. Resident # F then reported the incident on 7/5/11 to the Director of Nursing who failed to suspend CNA #2				administration at this facility.	
					Resident #D has since been	
					discharged from the facility.	
					Because the facility was not aw	rare of
					these allegations during her admission, an investigation into	thia
					alleged incident did not occur.	) tills
	and protect other	residents from potential			unogou moruoni uiu noi oooui.	
	harm during inve	estigation of the alleged			Regarding Resident #F, the resi	
	abuse. The Admi	nistrator and the Director			did not report to the facility tha	
	of Nursing (DON	N) were notified of the			had been thrown into bed. This allegation was not revealed to	3
	immediate jeopai	rdy at 5:30 P.M. on			administration until the ISDH	
	7/13/11. The im	mediate jeopardy was:			complaint surveyor interviewed	l the
	removed on 7/15	/11, but noncompliance		/		
	remained at the le	ower scope and severity			became aware of this allegation	·
	of pattern, no act	ual harm with potential			CNA #2 was immediately susponed and an investigation was started	
	for more than mi	nimal harm that is not			CNA #2 was terminated on 7/1	
	immediate jeopai	rdy.			The surveyor was aware of this	
					incident during the survey, and	
	Findings include	:			follow-up report was sent to IS	
					informing them of the facility's conclusion to the investigation	l l
	1. Review of a fa	cility "Incident Report,"			7/19/11.	011
	dated 5/3/11, ind	icated, "(Resident #B)				
	alleges that on M	Ionday, 5-2-11, a CNA			Regarding Resident #G, CNA #	l l
	who gave her a s	hower treated her roughly			terminated on 5/9/11 and CNA	#15
	and had a "bad at	ttitude." She reported			was terminated on 7/12/11.	
		yed in the face with the			Mandatory in-services began	
	shower sprayer	."				

002662

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684			LDING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/15/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  6450 MIAMI CIRCLE  SOUTH BEND, IN46614				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	dated 5/3/11, and indicated, "Natur (#B) reported rou attitude of CNA; repeatedly for be #B thought she h charge' to not have with her care. Lat #8) came to do (I (Resident #8) repeatedly for be the face, and (CN her wishes concested clothing"  During interview 7/12/11 at 2:30 P was unaware Rese #8 not be assigned An "Investigation and signed by RN previous week N called (Name), D conflict between #8). (Resident #8) in her room. that nite (sic) and conversation at the Wed., April 27th	ily Concern Report," I signed by the Chaplain, ie of Concern: Resident igh handling and bad #8 when resident asked d pan last week. Resident ad asked 'someone in we this CNA (#8) help ast evening, 5/2/11, (CNA Resident #B's) shower. Forted she was sprayed in IVA #8) was not following arning (Resident #B's)  To with the DON on To M., she indicated she resident #B requested CNA and to provide her care.  The proof of the concern and the concern			immediately upon the facility becoming aware of the immedi jeopardy citation on 7/13/11. A staff members were educated be the beginning of their next shift the proper protocol to report about what types of things to report, a what to do if the report is not followed up on. Staff members instructed to notify the Administrator, or designee in the Administrator's absence, immediately upon becoming an of any abuse allegation. In-serfor all staff were completed by 7/18/11. (Attachment A)  Management and on-call nursing staff were in-serviced on 7/14/17 review proper protocol for report abuse. (Included in Attachment The facility Administrator review the facility's policies and procedure garding abuse and neglect on 7/13/11. They were found to be reasonable and accurate. Howe after further review, minor modifications were made to the policy, "Abuse- Identification of Protection of the Resident" to simplify the language and the procedure for staff members. (Attachment B)  The facility Medical Director we notified of the immediate jeopacitation on 7/14/11.	All efore t on: guse, gand s were ne ware vices  ng 11 to orting t A) ewed dures e ever, e of and	
	7/11/11 at 3:20 P				The phone numbers of the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ΓED
		155684	B. WIN			07/15/201	11
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
0011711	-151 5 \ // 1 4 6 5			1	IAMI CIRCLE		
SOUTH	FIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	documentation o	of an investigation, a State	İ		Administrator and Director of	1	
		seling, or disciplinary			Nursing were posted in multiple	e	
	_	the issue reported by			locations on 7/14/11 in order for	r any	
					staff member to directly notify		
	1	ing Resident #B's			administration of any allegation	ıs of	
		eged rough handling by			abuse, at any time.		
	CNA #8 when as	ssisting her with the					
	bedpan (4/27/11)	).			The form used as a guide for		
	] - `				discussion in daily stand-up me	-	
	Resident #B's closed clinical record was				was revised on 7/14/11 to inclu	I .	
	reviewed on 7/11/11 at 3:45 P.M., and				statement, "Allegations of abus	e or	
					neglect?" (Attachment C)		
	indicated diagnoses of, but not limited to,				In order to ensure all staff are		
	congestive heart failure, hypertension				educated on abuse and neglect	on an	
	(high blood pres	sure), and severe			ongoing basis, the facility will	)II dii	
	osteoporosis (ab	normal loss of bone			continue to provide education of	on this	
		tial MDS (Minimum Data		subject upon hire and at least twice			
	1	, dated 4/15/11, indicated			annually.		
	1 '						
		tely cognitively impaired			In order to monitor and ensure	that	
	with a score of 1	2 out of 15.	abuse policies are followed, the			,	
					Administrator or her designee,	will	
	2. The closed cl	inical record of Resident			randomly interview five resider	its per	
	#D was reviewed	d on 7/12/11 at 10:45			week for a time period of no les		
	A M and indicat	ted diagnoses of, but not			than six months as to how staff		
		oral compression fracture,			members have been treating the		
	· ·	*			Any concerns will be thorough	.y	
		ration (progressive			investigated. (Attachment D)		
		the eye which leads to					
	/	heral vascular disease			Results of the monitoring progr		
	(restricted blood	flow), fractured left hip,			will be reviewed at the monthly		
	I '	sis (narrowing of the			(Continuous Quality Improvem		
	vertebrae).	, <i>5</i>			meeting. Areas of non-complia		
	/ Cricordoj.				will be addressed immediately.		
	Dumin = int : :	v vvitle Dagidant #D!			Alleged date of compliance is		
		w with Resident #D's			7/18/2011.		
	1 -	/11 at 2:15 P.M.,			,,10,2011.		
	Resident #D's da	nughter indicated her					
	mother had told	her that a night CNA					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		(X2) MUI A. BUILD B. WING		NSTRUCTION  00	(X3) DATE: COMPL 07/15/2	ETED	
	PROVIDER OR SUPPLIER			6450 MI	DDRESS, CITY, STATE, ZIP CODE AMI CIRCLE BEND, IN46614	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	cussed at her, thr her "I'm tired of light. I'm tired of "My mother comme. They're mean thought my moth when the bruises evident, I went to concerns. I told he CNA as (race standon by said, 'We do stated) girl working in bed and individual which tall."  In a second interedaughter on 7/12 indicated she ask could remember who was rough we stated) girl in the "She did complain about the treatment when the bruises hospital. Mother her around and sight she told them, 'But break my hip, ag Review of Reside (Minimum Data 5/18/11, indicate	ew her in bed, and told you using that dn call coming into your room. plained 'They're mean to in to me.' I, at first, her was imagining it, but and tremors were to the DON with my her mother described the ted), tall woman. The on't have a tall (race hing here.' My mother was looking up at the probably made her look wiew with Resident #D's //11 at 9:20 A.M., she hed her mother if she the name of the CNA with her. "It was a (race middle of the night." In to the DON (Name) ent. We were very upset were discovered at the remembers them shoving lamming her into bed and he careful your going to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6WFT11

Facility ID:

002662

If continuation sheet

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	ETED
		155684	B. WIN	G		07/15/20	011
NAME OF I	PROVIDER OR SUPPLIER	<u>!</u>	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	IAMI CIRCLE		
SOUTHF	FIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	D	'4 4 DON					
	"	with the DON on					
		A.M., she indicated she					
		ate with the resident that					
	the CNA was just hurrying. She further						
	indicated, as a result, she did not feel						
	there was a need to do a State Reportable.						
	The Nursing staf						
	and indicated CNA #15 was the only (race						
	stated) CNA who provided care to						
	Resident #D on the night shift. The May						
		chedules indicated CNA					
	1						
		provide care to Resident					
		ring dates: 5/24, 5/31, 6/7,					
	6/14, 6/18, and 6	/19/11.					
	CNA #15's Perso	onnel File was reviewed					
	on 7/12/11 at 4:1	5 P.M. and lacked					
	documentation of	r any proof of					
		arding Resident #D or					
		ged abuse by CNA #15.					
	, , , , , , , ,	<i>,</i>					
	Resident #D's cli	nical record also lacked					
	documentation o	f alleged abuse or					
	investigation of a	any alleged abuse.					
	During interview	w with CNA #14 on					
	5/13/11 at 5:50 A	A.M., she indicated					
	residents frequen	tly complained to her					
	about a particula	r CNA refusing to toilet a					
	resident. "I overl	neard (CNA #15) being					
		t. I heard her tell the					
	resident, 'I can't t	ake you to the bathroom					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155684		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE COMP 07/15/2	LETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIRCLE SOUTH BEND, IN46614				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	Three or four of	went 10 minutes ago.' us girls have gone to the ing seems to be done					
	5/13/11 at 5:45 A #15) came to me tired of answerin light and I would #15) said, "She's When queried if	ed in an interview on A.M., One night (CNA and told me she was a (Resident #G's) call have to do it. (CNA getting on my nerves." she reported it to the tated, "No, but I talked other nurse."					
	7/13/11 at 5:50 A resident complai left in bed. CNA to the bathroom	with CNA #17 on A.M., she indicated a ned to her that she was #15 would not take her when she needed to go. ed, but she really gushed					
	reviewed on 7/13 indicated diagno depression, osteo	clinical record was 3/11 at 4:00 P.M. and ses of, but not limited to, parthritis, and severe (narrowing of the spine).					
	7/13/11 at 5:25 A several residents	with CNA # 4 on A.M., she indicated have complained to her being rough with them.					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155684	B. WING		07/15/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
COLITUE			l l	IIAMI CIRCLE	
	FIELD VILLAGE			H BEND, IN46614	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAG		·	IAG		DATE
		ho those residents were, sident #F and Resident			
		tion lead to conducted ooth Resident #F and			
	Resident #G. (However, Resident #F indicated in the interview on 7/13/11 that				
	it was CNA #2 w	ho allegedly abused her.)			
	Resident # F was	identified as alert and			
	oriented to person, place, and time by her				
	physician in a History and Physical				
	Report, dated 6/14/11, and by Social				
		during an interview on			
		P.M. Resident #F's 14			
	day MDS (Minir				
		ed 6/17/11, indicted she			
		intact. She was admitted			
		6/7/11 from an acute			
	hospital.	0///11 Holli all acute			
	nospitai.				
	During interview	with Resident #F on			
	7/13/11 at 9:15 A	A.M., she indicated that			
	about 2 weeks ag	go, CNA #2 came into her			
	room to assist he	r to the bathroom. CNA			
	#2 insisted on pu	tting Resident #F's			
	back-brace on w	hile she was sitting down.			
	Resident #F told	CNA #2 that Physical			
	Therapist #6 told	her she should be			
	_	e brace is put on her.			
	CNA #2 respond	ed, "I'll do it my way."			
	_	er put the brace on while			
		ne was desperate to get to			
		hen she finished in the			
		#2 assisted her to her bed.			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED
		155684	A. BUILDING B. WING		07/15/2011
				T ADDRESS, CITY, STATE, ZIP CODE	_
NAME OF I	PROVIDER OR SUPPLIER			MIAMI CIRCLE	
SOUTHF	FIELD VILLAGE		SOUT	TH BEND, IN46614	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAG			IAG	Dirichi.(CT)	DATE
	1	in, confronted CNA #2, ng the position of the side			
		• •			
	rail on the bed. Resident #F informed CNA #2 that Physical Therapist #6 taught				
	her to get into bed with the side rail down				
	so she could position her body up higher				
	on the mattress. CNA #2 replied in a				
		I'm not the therapist."			
	I	cated she was sitting on			
		d when CNA #2 grabbed			
		C			
	her by the sleeve and pulled her down toward the foot of the bed. "She then				
		ders down on the bed,			
	1 -	from my w/c onto the			
	1 ^	sheet I used to cover my			
	1	here. When she got angry			
	1 * .	d as an apple. I was			
	1	ould get injured. I just			
	1	I don't want to have gone			
	1	ain for nothing. I'm just			
		over." Resident #F			
		ald not get anyone to help			
		e saw CNA #3 outside			
	1	ved to her and she came			
		e. "She said, Oh dear,			
		you? I told her what			
		e to me." Resident #F			
	indicated CNA #				
		restricted her ability to			
		they managed to get her			
	_	he rescued me." When			
	_	e incident and what			
	l ^	feeling at the time, she			
		s fearful of CNA #2.			
				•	<del></del>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		A. BUII	LDING	NSTRUCTION  00	(X3) DATE: COMPL 07/15/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  AMI CIRCLE BEND, IN46614	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	provided her care isn't near me, but didn't have to see indicated she told (DON) the next of how she had frighthe DON was shown ever had any provided the past. "She told be assigned to tal further indicated filed a report their ramifications as a same and the provided the poor indicated filed and the provided the pr	ted in an interview on A.M. that she had not #2 because Resident #F to her that CNA #2 threw that she was bossy and red and left her feet red. "Forty-five minutes ght clarification, Resident ret were on the bed and ret oget her call light." In indicated CNA #2 was rorkers.  The cord lacked from investigation, a State seling, or disciplinary the issue reported to the					

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE  (X4) ID PREFIX TAG  During an interview with the DON on 7/13/11 at 2:30 P.M., evidence of an investigation of the incident between Resident #F and CNA #2 on 7/4/11 was requested from the DON, The DON indicated she would retrieve it from her office but, just minutes later, the DON was observed interviewing LPN #7 regarding the incident that had been reported 8 days previously (7/5/11). The DON admitted she had not written up an investigation. When queried if she could produce any of the report, she produced a statement by CNA #2, dated 7/5/11.  There was no other documentation which indicated suspension, investigation,	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
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CAMB OF PROVIDER OR SUPPLIER			155684	B. WING			07/15/2	011
SOUTHFIELD VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  During an interview with the DON on 7/13/11 at 2:30 P.M., evidence of an investigation of the incident between Resident #F and CNA #2 on 7/4/11 was requested from the DON. The DON indicated she would retrieve it from her office but, just minutes later, the DON was observed interviewing LPN #7 regarding the incident that had been reported 8 days previously (7/5/11). The DON admitted she had not written up an investigation. When queried if she could produce any of the report, she produced a statement by CNA #2, dated 7/5/11. There was no other documentation which	NAME OF P	PROVIDER OR SUPPLIER		ST	REET A	ADDRESS, CITY, STATE, ZIP CODE		
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7/13/11 at 2:30 P.M., evidence of an investigation of the incident between Resident #F and CNA #2 on 7/4/11 was requested from the DON. The DON indicated she would retrieve it from her office but, just minutes later, the DON was observed interviewing LPN #7 regarding the incident that had been reported 8 days previously (7/5/11). The DON admitted she had not written up an investigation. When queried if she could produce any of the report, she produced a statement by CNA #2, dated 7/5/11.  There was no other documentation which	TAG		·	TA	.G	DEFICIENCY)		DATE
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statement by CNA #2, dated 7/5/11. There was no other documentation which			•				i	
There was no other documentation which		1 *	• •					
		I -					i	
indicated suspension, investigation,							i	
		1	_					
counseling, or disciplinary action had		counseling, or di	sciplinary action had				i	
taken place. In her statement of 7/5/11,		taken place. In h	ner statement of 7/5/11,				i	
CNA #2 relayed a completely different		CNA #2 relayed	a completely different				i	
story of the incident. CNA #2 indicated		story of the incid	lent. CNA #2 indicated					
Resident #F wanted to go to the bathroom			C				i	
and get into bed, but she informed the		and get into bed,	but she informed the				i	
resident that the nurse would like her to		resident that the	nurse would like her to					
sit up in the recliner. "She told me to put		sit up in the recli	ner. "She told me to put					
down the side rail. I told her to let me		down the side rai	il. I told her to let me					
show her how we transfer with the rail up,		show her how we	e transfer with the rail up,				i	
so she could grab it. I helped he (sic) into		so she could grat	o it. I helped he (sic) into					
bed and lifted her legs into bed. She got		bed and lifted he	r legs into bed. She got					
mad at me for not putting down the side		mad at me for no	ot putting down the side					
rail and asked to see the nurse." CNA #2		rail and asked to	see the nurse." CNA #2					
indicated she went to LPN #7 and told her		indicated she we	nt to LPN #7 and told her					
two or three times that Resident #F		two or three time	es that Resident #F					
wanted to see her, but LPN #7 was too		wanted to see he	r, but LPN #7 was too					
busy. The DON was observed on 7/13/11		busy. The DON	was observed on 7/13/11					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		A. BU	ILDING	00 	COMPI 07/15/2	LETED	
		100004	B. WI			01/10/2	.011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SOUTHF	FIELD VILLAGE		SOUTH BEND, IN46614				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		ting the statement					
	1	vided her on 7/5/11, but					
		oduce documentation to					
	indicate other residents and staff had been						
	interviewed as part of an investigation.						
	During a telephone conversation on						
	7/13/11 at 2:50 P.M. with CNA #3, while in the presence of the DON and with the						
		on, CNA #3 indicated					
	1 ^ ^						
	she found Resident #F sideways in her bed. She further indicated Resident #F						
	told her CNA #2 "threw her into bed and						
	left her there." CNA #3 and LPN #7 failed						
	_	dent to the DON, but voiced mistreatment to					
	her on 7/5/11.	voiced mistreatment to					
	Het OH //3/11.						
	4. During interv	iew with Resident #G on					
	7/13/11 at 10:35	A.M., she indicated she					
	was fearful of us	ing her call light because					
	she had been yel	led at by a staff person					
	for having to go	to the bathroom so much.					
	"She would get a	ingry when I had to go the					
	bathroom. She w	as yelling 'Ever since					
	they removed the	e catheter you've been a					
	problem.' When	someone knocks, I jump.					
		sorry, but I couldn't help					
	it. Every time th	is need comes up (to use					
	the bathroom) I g	get frightened. Recently, I					
	had my light on,	but no one came. I hurt					
	because the press	sure was so great. I took					
	my blanket and f	folded it into a square					
	and tucked it und	ler me so I could pee on					
	it without getting	g the rest of my bed wet.					

002662

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155684	B. WIN			07/15/2	011
NAME OF S	DROLLIDED OD GLIDDLIE	\	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		6450 M	IAMI CIRCLE		
	FIELD VILLAGE				I BEND, IN46614		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)	-	TAG	BEFFERET		DATE
	_	(Social Service Staff #5)					
	and the DON.						
		taff #5 indicated in an					
	interview on 7/13/11 at 12:00 P.M. that he						
		ware of the situation and					
		ident #G to discuss her					
	1 -	cated this latest incident					
		a call light being					
	answered happened on Monday, 7/11/11.						
	"Resident #G has impaired vision and she						
	was uncertain of	the time, but she					
	believed it was e	early morning around 5:00					
	A.M."						
	During interview	with the DON on					
	7/13/11 at 5:00 I	P.M., regarding the					
	allegations made	by Resident #G during					
	interview with h	er on 7/13/11, she					
	1	still investigating the call					
	light issue.						
	Review of an "Ir	nternal Investigation"					
		5/11, indicated, "Date of					
	1 * '	/11? or 4/3/11 Saturday					
		on of Occurrence:					
	1 -	o (complained of) a staff					
	1 '	ining that she wants to go					
	1	a lot and that her hands					
		abbed her by the hands to					
	1	bathroom" A "Resident					
	1	rt, dated 4/4/11, indicated,					
	1	ve vision and I can seeI					
		ng the night or late					
	1						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155684	B. WING		07/15/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
COLITUE	FIELD VILLAGE			∕IIAMI CIRCLE H BEND, IN46614	
	_			1 DEIND, IIN40014	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAG		all about me having to go	IAG		DAIL
	1	This person was saying			
	_	to the bathroom all of the a time when I was. She			
	1	lem. She was angry kind need to do something			
		•			
		nds are tender and she			
		ands to take into the			
	bathroom. They	are sore"			
	A sittem statement 1 DNI // 11 m late 1				
	A written statement by RN # 11, undated, indicated, "At 12 A (12:00 A.M.) 4/3/11,				
	· ·	, , , , , , , , , , , , , , , , , , , ,			
	<b>l</b> `	egan to tell me of an			
		said happened last night.			
	_	rify the time frame, but			
		I gathered enough			
		all in the morning to on			
	1 ^	7:45 A. MWhen I			
		(Supervisor), she called			
	` ′	d requested a full			
		dy check. Resident			
		t happened as it occurred.			
	` ′	dn't remember putting on			
		neone came in, (Resident			
		at her. The following are			
	statement conten				
		a go (urinate) more than			
	l -	Resident (#G) said she			
	1	he bathroom. "I know			
	l -	going pee"Someone			
	l -	ls and was rough moving			
	her around. "You	u need to do something			
	about your bladd	er. You need to get your			
	bladder checked.	There is something			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SUF	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ED
		155684	B. WIN			07/15/201	1
NAME OF I					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF E	PROVIDER OR SUPPLIER			6450 M	IAMI CIRCLE		
	TIELD VILLAGE				I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	OMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAU		•	DATE
	"	Resident (#G) replied,					
	"That may be true). (Resident #G) used						
		il.' The person kept					
	-	ut the event to the					
		ck. (Resident #G) said					
		and she was shaking all					
		er hands hurt when they					
	grabbed them"	•					
	The "Internal Investigation" further						
	indicated Resident G's son made the statement, "I think this story about						
	someone compla	ining about her going to					
	the bathroom a lo	ot comes from when she					
	was first here. I	know she is really					
	sensitive when it	comes to her arms and					
	wrists" Repor	t "Conclusion: (Resident					
	#G) suffers from	confusion. Statements					
	from staff are pro	oviding nothing					
	1	son seems to think that					
		an old idea" Resident					
		ord indicated she was					
		acility from an acute care					
	hospital on 3/3/1						
	A "Resident/Fam	nily Concern Report,"					
		d signed by the DON,					
		cerning Resident #G					
		rn: This writer noted					
		down the hall in her					
	_	g pushed by (CNA #13), I					
	_	#G) how she was doing.					
	· '	ry good right now.' Upon					
	rurmer questionii	ng she complained that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684			ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155684	B. WIN			07/15/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	DDRESS, CITY, STATE, ZIP CODE		
SOUTHF	FIELD VILLAGE			1	IAMI CIRCLE BEND, IN46614		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		s complained that she was					
	ı ^ ~	hI questioned (CNA					
	l ''	NA in her room this					
	`	A #8) said 'I didn't say					
	that, I just took h	ner to the bathroom."					
	Explained to CN	IA (#8) that resident's					
	many times have	e (sic) to urinate					
	frequently for di	fferent reasons and that					
	we can't judge th	nis. We merely take them					
	to the bathroomResolution and						
	Disposition: "CNA apologized to						
	resident.						
	A letter to the Indiana State Department of						
		9/11, which included the					
	· ·	(regarding CNA #8 and					
	1 ^	on by Resident #B)					
		•					
		NA #8) was also involved					
		complaint made by					
	· ·	(Resident #G). She					
		o CNA's complained that					
		frequently. One of these					
	CNA's was (CNA	Α #8 <b>)</b> "					
	Resident #G's cl	inical record and the					
		f CNA #8, lacked					
		hat the $4/2/11$ and the					
		nt of alleged abuse by					
	1 ^	re reported to State					
		as briefly mentioned (21					
		above letter and incident					
	report, dated 5/9						
	Toport, dated 3/9	/ 11.					
	Review of Resid	lent #G's clinical record					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155684	A. BUILDING	00	COMPLETED 07/15/2011
		100004	B. WING		07/15/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
SOUTHE	FIELD VILLAGE		I	IIAMI CIRCLE I BEND, IN46614	
	_	TATEL IENT OF DEPLOYED ONE		1 52115, 11140014	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		:00 A.M., indicated			
	diagnoses of, but				
		miparesis, and legally			
	1 **	y MDS (Minimum Data			
		dated 5/31/11, indicated			
		sion was severely			
	impaired, she wa	s occasionally			
	incontinent of ur	ine, and needed limited			
	assistance of one	for toileting. She scored			
	11 of 15 for cogn	nicity, which indicated			
	she was moderately impaired.				
	Review of a facil	lity policy titled "Primary			
	Abuse Prohibitio	n Policy," dated 9/2000,			
	indicated, "Policy	y: It shall be the policy			
	of Southfield Vil	lage that all residents of			
	this facility are fi	ree from verbal, sexual,			
	physical, and me	ntal abuse, corporal			
	punishment and i	involuntary			
	seclusionPolicy				
		cation ofProcedure: 1.			
	_	visory personnel will be			
		potential for abuse of			
		Administrator will be			
	_	nonitoring quality			
	_	ality improvement			
		for patterns, occurrences			
		ould be suggestive of			
		within the facility. 3.			
		or will be responsible for			
	ı	ent/accident reports for			
	potential				
	_	tionProcedure:3.			
	Staff incidents w	hich involve abuse,			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155684	B. WIN			07/15/20	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	IAMI CIRCLE		
SOUTHF	FIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	<b>\</b>	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DIA ICILIACT)		DATE
		vestigated as follows: 3.1					
	The staff member is suspended immediately without pay pending						
	1						
	_	is the intent of the					
	I -	e an investigation within					
	3-5 days"						
	The immediate jeopardy that began on 7/5/11 was removed on 7/15/11 when the facility suspended the staff accused of						
	alleged abuse and began investigations, began immediate mandatory in-services						
	1	ols to follow regarding					
		et, reviewed facility's					
		procedure and found it					
		and accurate, met with					
	I -	staff and on-call nursing					
	1	cotocol for reporting					
		e daily stand-up meeting					
		allegations of abuse and					
	1 -	the facility Medical					
		nmediate jeopardy,					
	posted phone nui	mbers of the					
		d Director of Nursing in					
	multiple location	s of the facility with					
		nmediately report any					
	allegation of abu	se at any time, ensured					
	the Administrato	r or her designee will					
	monitor abuse pr	otocol by randomly					
	interviewing five	e residents per week for					
		nonths, and ensured the					
	facility will conti	inue to provide abuse and					
	neglect education	n upon hire and at least					
	twice annually, b	out the noncompliance					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684	A. BUILDING	E CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/15/2011
	PROVIDER OR SUPPLIER		6450	ET ADDRESS, CITY, STATE, ZIP CODE  O MIAMI CIRCLE  JTH BEND, IN46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	of pattern, no act for more than mi immediate jeopa continued to reco and monitor staff to follow the con	ower scope and severity ual harm with potential nimal harm that is not rdy to ensure staff ognize and report abuse if to ensure they continued rective action plan.  relates to complaint IN			
F0226 SS=L	written policies an mistreatment, neg and misappropriat Based on intervioral facility failed to protocol regarding ensure staff recomplysical and very immediately reported the Administrator prevent the abuse	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. Ew and record review, the implement their written ag abuse and neglect to gnized allegations of boal abuse and ported those allegations to a for investigation to be from reoccurring. This is affected 2 of 4 residents	F0226	F 226  Regarding Resident #B, CNA # suspended on 5/4/11 after the fabecame aware of the allegation. CNA was terminated on 5/9/20 following an investigation into matter. This incident was report ISDH on 5/3/11.  Regarding Resident #D, the face	acility The II the tted to

002662

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155684 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6450 MIAMI CIRCLE SOUTHFIELD VILLAGE SOUTH BEND, IN46614 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (Residents: #B, #D) reviewed for abuse in has reviewed all grievances from this resident and/or family members and the sample of 4 and 2 of 6 residents the facility alleges that this allegation (Residents: #F, #G) in the supplemental was never reported to any member of sample of 6 with the potential to affect all administration at this facility. 60 residents residing in the facility. Resident #D has since been discharged from the facility. Because the facility was not aware of The immediate jeopardy began on 7/05/11 these allegations during her when Resident # F, who was recovering admission, an investigation into this from recent back surgery, reported to alleged incident did not occur. CNA #3 on 7/4/11 that CNA #2 had Regarding Resident #F, the resident thrown her into bed and left her sideways did not report to the facility that she in the bed. Resident # F then reported the had been thrown into bed. This incident on 7/5/11 to the Director of allegation was not revealed to Nursing who failed to suspend CNA #2 administration until the ISDH and protect other residents from potential complaint surveyor interviewed the resident. As soon as the facility harm during investigation of the alleged became aware of this allegation, abuse. The Administrator and the Director CNA #2 was immediately suspended of Nursing (DON) were notified of the and an investigation was started. immediate jeopardy at 5:30 P.M. on CNA #2 was terminated on 7/19/11. 7/13/11. The immediate jeopardy was: The surveyor was aware of this incident during the survey, and a removed on 7/15/11, but noncompliance follow-up report was sent to ISDH remained at the lower scope and severity informing them of the facility's of pattern, no actual harm with potential conclusion to the investigation on for more than minimal harm that is not 7/19/11. immediate jeopardy. Regarding Resident #G, CNA #8 was terminated on 5/9/11 and CNA #15 Findings include: was terminated on 7/12/11. 1. Review of a facility "Incident Report," Mandatory in-services began dated 5/3/11, indicated, "...(Resident #B) immediately upon the facility becoming aware of the immediate alleges that on Monday, 5-2-11, a CNA jeopardy citation on 7/13/11. All who gave her a shower treated her roughly staff members were educated before and had a "bad attitude." She reported the beginning of their next shift on: that she was sprayed in the face with the

Facility ID:

STATEMEN		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155684	B. WIN			07/15/2011
			<u> </u>		DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	AMI CIRCLE	
SOUTHF	IELD VILLAGE			1	BEND, IN46614	
(X4) ID	CHMMADV C	TATEMENT OF DEFICIENCIES		ID	·	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
					the proper protocol to report abo	
	shower sprayer	··			what types of things to report, a	
					what to do if the report is not	
		ily Concern Report,"			followed up on. Staff members	were
	dated 5/3/11, and signed by the Chaplain,				instructed to notify the	
	indicated, "Nature of Concern: Resident				Administrator, or designee in th	e
	(#B) reported rough handling and bad				Administrator's absence,	
	attitude of CNA #8 when resident asked				immediately upon becoming aw	
	repeatedly for be	d pan last week. Resident			of any abuse allegation. In-serv	rices
		ad asked 'someone in			for all staff were completed by	
	_				7/18/11. (Attachment A)	
	charge' to not have this CNA (#8) help				Management and on-call nursin	σ
	with her care. Last evening, 5/2/11, (CNA				staff were in-serviced on 7/14/1	- 1
	#8) came to do (Resident #B's) shower.				review proper protocol for repo	
	(Resident #8) reported she was sprayed in				abuse. (Included in Attachment	-
		NA #8) was not following				
	her wishes conce	erning (Resident #B's)			The facility Administrator revie	
	clothing"				the facility's policies and proceed	dures
					regarding abuse and neglect on	
	During interview	with the DON on			7/13/11. They were found to be	
	•	M., she indicated she			reasonable and accurate. Howe after further review, minor	ver,
		sident #B requested CNA			modifications were made to the	
		ed to provide her care.			policy, "Abuse- Identification o	
	#6 flot be assigne	du to provide her care.			Protection of the Resident" to	
	A 11T				simplify the language and the	
	_	n" report, dated 5/4/11			procedure for staff members.	
		N #9, indicated, "On			(Attachment B)	
	Monday, May 2n					
	(approximately)	9:00 P.M., I entered			The facility Medical Director w	
	(Resident #B's) (1	room number) with her			notified of the immediate jeopar	ray
	H.S. (bedtime) m	neds (medications).			citation on 7/14/11.	
	(CNA #8) had jus	· · · · · · · · · · · · · · · · · · ·			The phone numbers of the	
		id to me: 'I don't know			Administrator and Director of	
	` ′				Nursing were posted in multiple	.
	what is wrong with that girl. I don't like the way she handles me. When I saw her face I knew I was in for it'The previous				locations on 7/14/11 in order fo	
					staff member to directly notify	
					administration of any allegation	s of
	week Nurse (LPI	N #10) had called				
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	6WFT11	Facility II	D: 002662 If continuation sl	heet Page 45 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155684	B. WIN			07/15/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
NAME OF I	PROVIDER OR SUPPLIEF	2		1			
00117115				1	IAMI CIRCLE		
SOUTH	FIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Name), DON re	e: (regarding) a conflict			abuse, at any time.		
	between (Reside	ent #B) and (CNA #8).					
	(Resident #B) did not want (CNA #8) in her room. I was working Wing 200 that nite (sic) and overheard the phone				The form used as a guide for		
					discussion in daily stand-up me		
					was revised on 7/14/11 to inclu		
	` ′	•			statement, "Allegations of abus	e or	
	conversation at the nurses station on				neglect?" (Attachment C)		
	Wed., April 27th	ı."			In order to ensure all staff are		
	Review of the "CNA Evening				educated on abuse and neglect	on on	
					ongoing basis, the facility will	ni ali	
	Assignment," dated 5/2/11, indicated				continue to provide education of	n this	
	1				subject upon hire and at least tw		
CNA #8 had been assigned to (Resident				annually.	,,,,,,		
	#B's) room.				umuuny.		
					In order to monitor and ensure	that	
	Review of CNA	#8's personnel File on			abuse policies are followed, the	;	
	7/11/11 at 3:20 F	P.M. lacked			Administrator or her designee,	will	
	documentation of	of an investigation, a State			randomly interview five resider	ıts per	
		nseling, or disciplinary			week for a time period of no les	SS	
		the issue reported by			than six months as to how staff		
					members have been treating the		
	1	ing Resident #B's			Any concerns will be thoroughly	y	
		eged rough handling by			investigated. (Attachment D)		
	CNA #8 when as	ssisting her with the			B 1. 63		
	bedpan (4/27/11)	).			Results of the monitoring progr		
					will be reviewed at the monthly	-	
	An "Employee (	Counseling Form," dated			(Continuous Quality Improvem		
	1	CNA #8 was suspended			meeting. Areas of non-complia will be addressed immediately.	.nce	
	· '	*			will be addressed illilliculatery.		
		nvestigation. The DON			Alleged date of compliance is		
		interview on 7/12/11 at			7/18/2011.		
	2:30 P.M. that C	NA #8 had been			,,10,2011.		
	terminated on 5/	9/11.					
	Resident #B's closed clinical record was reviewed on 7/11/11 at 3:45 P.M., and						
		ses of, but not limited to,					
	congestive heart	failure, hypertension	- 1				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
		155684	A. BUI B. WIN	LDING IG		07/15/2	011
NAME OF	DD OVADED OD GUDDU IEI		P. 111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		6450 M	IAMI CIRCLE		
SOUTH	FIELD VILLAGE			SOUTH	BEND, IN46614		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG	•	sure), and severe		IAG	,		DAIL
	1	normal loss of bone					
	density). An initial MDS (Minimum Data						
	1	, dated 4/15/11, indicated					
	1 ′	tely cognitively impaired					
	with a score of 1						
	With a score of f	2 out 01 10.					
	2. The closed clinical record of Resident						
	#D was reviewed on 7/12/11 at 10:45						
	A.M. and indicated diagnoses of, but not						
	limited to, vertebral compression fracture,						
	macular degeneration (progressive						
		the eye which leads to					
		heral vascular disease					
	1	flow), fractured left hip,					
	1 '	sis (narrowing of the					
	vertebrae).						
	During interview	w with Resident #D's					
	~	/11 at 2:15 P.M., she					
		other had told her that a					
	1	ed at her, threw her in					
	1	"I'm tired of you using					
	1	nt. I'm tired of coming					
	1 -	"My mother complained					
	1 -	me. They're mean to me.'					
	'	t my mother was					
	1 -	when the bruises and					
		ident, I went to the DON					
	1 · ·	s. I told her mother					
	1	NA as being a (race					
	1 ''	an. The DON said, 'We					
	1	(race stated) girl working					
	here.' My mothe	er was lying in bed and					

002662

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155684	B. WIN			07/15/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE IAMI CIRCLE		
SOUTHF	FIELD VILLAGE			1	BEND, IN46614		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAU		e individual which	-	IAU			DATE
	probably made h						
	In a second inter	minor mids Davidant #Dla					
	In a second interview with Resident #D's daughter on 7/12/11 at 9:20 A.M., she						
	1	ked her mother if she					
		the name of the CNA					
		with her. "It was a (race					
		e middle of the night."					
	"She did complain to the DON (Name)						
	about the treatment. We were very upset						
	when the bruises were discovered at the						
	1 -	remembers them shoving					
		slamming her into bed and					
		Be careful your going to					
	break my hip, ag	gain.' "					
	Review of Resid	lent #D's initial MDS					
	(Minimum Data	Set) Assessment, dated					
		ed she was cognitively					
	intact with a sco	re of 15 out of 15.					
	During interviev	w with the DON on					
	7/12/11 at 10:35	A.M., she indicated she					
	was able to valid	late with the resident that					
	ı	st hurrying. She further					
		esult, she did not feel					
	there was a need	to do a State Reportable.					
	The Nursing star	ff schedule was reviewed					
	and indicated Ci	NA #15 was the only (race					
	· '	o provided care to					
		the night shift. The May					
	and June, 2011 s	schedules indicated CNA					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	li i	e survey Pleted //2011
	PROVIDER OR SUPPLIEF		6450 M	ADDRESS, CITY, STATE, ZIP CO IAMI CIRCLE I BEND, IN46614	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		provide care to Resident ving dates: 5/24, 5/31, 6/7, 5/19/11.				
	on 7/12/11 at 4:1 documentation of investigation or investigation or investigation.	reporting to State buse allegations by				
	documentation of	inical record also lacked f alleged abuse or any alleged abuse.				
	reviewed on 7/13 indicated diagno depression, osteo	clinical record was 3/11 at 4:00 P.M. and ses of, but not limited to, parthritis, and severe (narrowing of the spine).				
	7/13/11 at 5:25 A several residents about CNA #15 When queried w she indicated Re #G. Her information interviews with Resident #G. (H	with CNA # 4 on A.M., she indicated have complained to her being rough with them. ho those residents were, sident #F and Resident ation lead to conducted both Resident #F and lowever, Resident #F CNA #2 who allegedly				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155684	A. BUI	LDING	00	07/15/2	
		133004	B. WIN			01/13/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	FIELD VILLAGE			1	IAMI CIRCLE I BEND, IN46614		
	_				I DEND, INTOUT		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	<del>                                     </del>	identified as alert and	1				
		n, place, and time by her					
	physician in a History and Physical						
	1 * *	4/11, and by Social					
	_	during an interview on					
		P.M. Resident #F's 14					
	day MDS (Minin						
	1 * `	ed 6/17/11, indicted she					
	· ·	ntact. She was admitted					
	to the facility on 6/7/11 from an acute						
	hospital.						
	F						
	During interview with Resident #F on						
		.M., she indicated that					
		go, CNA #2 came into her					
	٦ - ١	r to the bathroom. CNA					
	#2 insisted on pu	tting Resident #F's					
	_	hile she was sitting down.					
		CNA #2 that Physical					
		her she should be					
	1 ^	e brace is put on her.					
		ed, "I'll do it my way."					
	1 ^	er put the brace on while					
		ne was desperate to get to					
	1 ~	hen she finished in the					
	bathroom, CNA	#2 assisted her to her bed.					
	Resident #F, aga	in, confronted CNA #2,					
	this time regarding	ng the position of the side					
	rail on the bed. I	Resident #F informed					
	CNA #2 that Phy	rsical Therapist #6 taught					
	_ ·	d with the side rail down					
	so she could posi	tion her body up higher					
	on the mattress.	CNA #2 replied in a					
	snotty manner, "	I'm not the therapist."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155684			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		STREET A 6450 M	ADDRESS, CITY, STATE, ZIP C IAMI CIRCLE I BEND, IN46614	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	the side of the beher by the sleeved toward the foot of pushed my should threw the pillow bed along with a lap, and left me ther face got as reafraid my back whad surgery and through all that pushed through all that pushed the condicated she conher, but when she her room she was to offer assistance what happened to CNA #2 had donindicated CNA # condition which lift, but together up in the bed. "Squeried about the Resident #F was indicated she told (DON) the next of how she had frig	cated she was sitting on ad when CNA #2 grabbed and pulled her down of the bed. "She then ders down on the bed, from my w/c onto the sheet I used to cover my there. When she got angry as an apple. I was would get injured. I just I don't want to have gone bain for nothing. I'm just over." Resident #F ald not get anyone to help the saw CNA #3 outside wed to her and she came the. "She said, Oh dear, to you? I told her what the to me." Resident #F ald a physical restricted her ability to they managed to get her the rescued me." When the incident and what feeling at the time, she is fearful of CNA #2. The incident and what feeling at the time, she is fearful of CNA #2. The incident was a point of the content of the conten				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO	N (X3) DAT	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  O	COM	PLETED
155684 B. WING	07/15	/2011
STREET ADDRESS. CI	TY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 6450 MIAMI CIRC	CLE	
SOUTHFIELD VILLAGE SOUTH BEND, IN		
	VIDER'S PLAN OF CORRECTION	(X5)
CROSS-RE	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	DEFICIENCT	DATE
never had any problems with CNA #2 in		
the past. "She told me CNA #2 would not		
be assigned to take care of me again." She		
further indicated the DON told her if she		
filed a report there could be legal		
ramifications as a result.		
The DON indicated in an interview on		
7/13/11 at 11:00 A.M. that she had not		
suspended CNA #2 because Resident #F		
did not mention to her that CNA #2 threw		
her into bed, but that she was bossy and		
put her into the bed and left her feet		
hanging off the bed. "Forty-five minutes		
later, when I sought clarification, Resident		
#F told me her feet were on the bed and		
she used her foot to get her call light."		
The DON further indicated CNA #2 was		
one of her best workers.		
During an interview with the DON on		
7/13/11 at 2:30 P.M., evidence of an		
investigation of the incident between		
Resident #F and CNA #2 on 7/4/11 was		
requested from the DON. The DON		
indicated she would retrieve it from her		
office, but, just minutes later, the DON		
was observed interviewing LPN #7		
regarding the incident that had been		
reported 8 days previously (7/5/11). The		
DON admitted she had not written up an		
investigation. When queried if she could		
produce any of the report, she produced a		
statement by CNA #2, dated 7/5/11.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  07/15/2011		
	PROVIDER OR SUPPLIEF	<b>  </b>	D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  AMI CIRCLE BEND, IN46614	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	There was no oth indicated suspen reporting to State or disciplinary as her statement of completely differed CNA #2 indicated go to the bathroom she informed the would like her to like to let me transfer with the it. I helped he (so legs into bed. So putting down the the nurse." CNA LPN #7 and told that Resident #F LPN #7 was too observed on 7/13 the statement Ref 7/5/11, but was an investigation. Conversation on CNA #3, while it DON and with the CNA #3 indicated sideways in her Resident #F told into bed and left.	ner documentation which sion, investigation, a authorities, counseling, authorities, counseling, ation had taken place. In 7/5/11, CNA #2 relayed a rent story of the incident. It desident #F wanted to a resident that the nurse of the incident in the resident that the nurse of the incident in the side rail. It is show her how we rail up, so she could grab sic) into bed and lifted her the got mad at me for not in the resident and asked to see #2 indicated she went to the her two or three times wanted to see her, but busy. The DON was 3/11 at 2:45 P.M., writing sident #F provided her on anable to produce or indicate other residents are interviewed as part of During a telephone 7/13/11 at 2:50 P.M. with the presence of the me "speaker phone" on, and she found Resident #F and the provident indicated ther CNA #2 "threw her her there." CNA #3 and the report the incident to the		TAG	DEFICIENCY)		DATE

	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S	
	155684	- 1			07/15/2	011
OVIDER OR SUPPLIER		•	6450 MI	IAMI CIRCLE	•	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
•						
was fearful of using the had been yell for having to go to She would get an eathroom. She was they removed the problem.' When so told them I was told them I was told them I was told my light on, I because the pressing blanket and found tucked it und to without getting reported that to and the DON.  Social Service Stanterview on 7/13	A.M., she indicated she ng her call light because ed at by a staff person to the bathroom so much. Ingry when I had to go the as yelling 'Ever since catheter you've been a omeone knocks, I jump. sorry, but I couldn't help is need comes up (to use et frightened. Recently, I but no one came. I hurt ture was so great. I took olded it into a square er me so I could pee on the rest of my bed wet. (Social Service Staff #5)					
eelings. He indic with the lack of a unswered happen Resident #G has was uncertain of the believed it was ea	ated this latest incident call light being ed on Monday, 7/11/11. impaired vision and she the time, but she					
	VIDER OR SUPPLIER  D VILLAGE  SUMMARY ST (EACH DEFICIENCE REGULATORY OR ID) ON, but Reside instreatment to he instreatment to he had been yelled or having to go to the shad been yelled or having to go to the would get an athroom. She was ney removed the roblem.' When so told them I was	VIDER OR SUPPLIER  LD VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DON, but Resident #F had voiced nistreatment to her on 7/5/11.  During interview with Resident #G on /13/11 at 10:35 A.M., she indicated she was fearful of using her call light because the had been yelled at by a staff person for having to go to the bathroom so much. She would get angry when I had to go the athroom. She was yelling 'Ever since the athroom. She was yelling 'Ever since the year removed the catheter you've been a roblem.' When someone knocks, I jump. told them I was sorry, but I couldn't help to the bathroom in get frightened. Recently, I ad my light on, but no one came. I hurt the ecause the pressure was so great. I took my blanket and folded it into a square and tucked it under me so I could pee on the without getting the rest of my bed wet. The reported that to (Social Service Staff #5) and the DON.  Docial Service Staff #5 indicated in an enterview on 7/13/11 at 12:00 P.M. that he had been made aware of the situation and the met with Resident #G to discuss her the process of the situation and the met with Resident #G to discuss her the process of the situation and the met with Resident #G to discuss her the process of the situation and the met with Resident #G to discuss her the process of the situation and the met with Resident #G to discuss her the process of the situation and the met with Resident #G to discuss her the process of the situation and the process of the situation and the met with Resident #G to discuss her the process of the situation and th	VIDER OR SUPPLIER  LD VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DON, but Resident #F had voiced instreatment to her on 7/5/11.  During interview with Resident #G on /13/11 at 10:35 A.M., she indicated she was fearful of using her call light because the had been yelled at by a staff person for having to go to the bathroom so much. She would get angry when I had to go the athroom. She was yelling 'Ever since the presence of the catheter you've been a roblem.' When someone knocks, I jump. It told them I was sorry, but I couldn't help to the bathroom. I get frightened. Recently, I add my light on, but no one came. I hurt the ecause the pressure was so great. I took the pressure was so great. I took the properties of the pressure was so great. I took the properties of the pressure was so great. I took the properties of the pressure was so great. I took the properties of the studies of the studies of the studies of the studies of the situation and the properties of the situation and the made aware of the situation and the met with Resident #G to discuss her the pressure was an analysis of the situation and the made aware of the situation and the met with Resident #G to discuss her the pressure was an analysis of the situation and the pressure was an analysis of the situation and the pressure was an analysis of the pressure was an analysis of the pressure was as a situation and the pressure was as a situation and the pressure was as an analysis of the pressure was as a situation and the pressure was as a situ	VIDER OR SUPPLIER  LD VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DON, but Resident #F had voiced nistreatment to her on 7/5/11.  During interview with Resident #G on /13/11 at 10:35 A.M., she indicated she vas fearful of using her call light because he had been yelled at by a staff person or having to go to the bathroom so much. She would get angry when I had to go the athroom. She was yelling 'Ever since ney removed the catheter you've been a roblem.' When someone knocks, I jump. told them I was sorry, but I couldn't help Every time this need comes up (to use ne bathroom) I get frightened. Recently, I and my light on, but no one came. I hurt ecause the pressure was so great. I took ny blanket and folded it into a square nd tucked it under me so I could pee on without getting the rest of my bed wet. reported that to (Social Service Staff #5) nd the DON.  ocial Service Staff #5 indicated in an interview on 7/13/11 at 12:00 P.M. that he ad been made aware of the situation and the met with Resident #G to discuss her eleings. He indicated this latest incident with the lack of a call light being nswered happened on Monday, 7/11/11.  Resident #G has impaired vision and she was uncertain of the time, but she elieved it was early morning around 5:00	VIDER OR SUPPLIER  LD VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCY  REGULATORY OR I.S. I IDENTIFYING INFORMATION)  ON, but Resident #F had voiced nistreatment to her on 7/5/11.  During interview with Resident #G on /13/11 at 10:35 A.M., she indicated she was fearful of using her call light because he had been yelled at by a staff person or having to go to the bathroom so much. She would get angry when I had to go the athroom. She was yelling 'Ever since nevy removed the catheter you've been a roblem.' When someone knocks, I jump. told them I was sorry, but I couldn't help is Every time this need comes up (to use ne bathroom) I get frightened. Recently, I ad my light on, but no one came. I hurt eccause the pressure was so great. I took my blanket and folded it into a square and tucked it under me so I could pee on without getting the rest of my bed wet. reported that to (Social Service Staff #5) and the DON.  ocial Service Staff #5 indicated in an aterview on 7/13/11 at 12:00 P.M. that he add been made aware of the situation and e met with Resident #G to discuss her eleings. He indicated this latest incident with the lack of a call light being nswered happened on Monday, 7/11/11. Resident #G to discuss her eleings. He indicated this latest incident with the lack of a call light being nswered happened on Monday, 7/11/11. Resident #G has impaired vision and she was uncertain of the time, but she elieved it was early morning around 5:00	DVILLAGE  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  DON, but Resident #F had voiced instreatment to her on 7/5/11.  During interview with Resident #G on /13/11 at 10:35 A.M., she indicated she ras fearful of using her call light because he had been yelled at by a staff person or having to go to the bathroom so much. She would get angry when I had to go the athroom. She was yelling 'Ever since ney removed the catheter you've been a roblem.' When someone knocks, I jump. told them I was sorry, but I couldn't help .  Every time this need comes up (to use the bathroom) I get frightened. Recently, I ad my light on, but no one came. I hurt ecause the pressure was so great. I took ny blanket and folded it into a square not tucked it under me so I could pee on without getting the rest of my bed wet. reported that to (Social Service Staff #5) and the DON.  ocial Service Staff #5 indicated in an neterview on 7/13/11 at 12:00 P.M. that he ad been made aware of the situation and e met with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good and she rate with Resident #G to discuss her each good

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		155684	B. WIN			07/15/2011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		6450 M	IAMI CIRCLE		
	TIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	COMPLETIO DATE	DN
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	IAU	Dia relative 17	DATE	
	D	id d. DON					
	During interview with the DON on 7/13/11 at 5:00 P.M., regarding the						
		by Resident #G during					
		er on 7/13/11, she					
		still investigating the call					
	Review of an "Internal Investigation" report, dated 4/15/11, it indicated, "Date of Occurrence: 4/2/11? or 4/3/11						
	Saturday night. Description of						
	, , ,	*					
	Occurrence: (Re	, , , , , , , , , , , , , , , , , , ,					
	(complained of)						
		she wants to go to the					
		nd that her hands hurt					
	_	l her by the hands to take					
	her into the bath	room" A "Resident					
	Statement" repor	t, dated 4/4/11, indicated,					
	"Sometimes I ha	ve vision and I can seeI					
	think it was during	ng the night or late					
	evening. It was a	all about me having to go					
	_	This person was saying					
		to the bathroom all of the					
	1	a time when I was. She					
		lem. She was angry kind					
	_	need to do something					
		nds are tender and she					
	l -	ands to take into the					
	bathroom. They						
	oaumoom. They	are sure					
	A written stateme	ent by RN # 11, undated,					
	indicated, "At 12	2 A (12:00 A.M.) 4/3/11,					
	· ·	egan to tell me of an					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/15/2	LETED	
		100004	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	07/15/2	.011
NAME OF I	PROVIDER OR SUPPLIER			1	IAMI CIRCLE		
SOUTHF	IELD VILLAGE			SOUTH	BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	incident that she	said happened last night.					
	Attempted to clar	rify the time frame, but					
	she was unsure.	I gathered enough					
	information to ca	all in the morning to on					
		7:45 A. MWhen I					
	l '	(Supervisor), she call					
	` ′	d requested a full					
		dy check. Resident					
		t happened as it occurred.					
	` ′	dn't remember putting on					
	_	neone came in, (Resident					
	#G) said yelling at her. The following are						
	statement conten						
		go (urinate) more than					
	l ř	Resident (#G) said she					
		he bathroom. "I know					
		joing pee"Someone					
	~	ls and was rough moving					
		u need to do something					
	· -	er. You need to get your					
		There is something					
	" "	' Resident (#G) replied,					
	1	e. (Resident #G) used					
		il.' The person kept					
	-	ut the event to the					
		ck. (Resident #G) said					
		and she was shaking all					
		er hands hurt when they					
	grabbed them"						
	The "Internal Inv	vestigation," dated "4/2/11					
		her indicated Resident					
		statement on 4/4/11, "I					
	think this story a						

	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		INSTRUCTION 00	(X3) DATE : COMPL	
		155684	A. BUII B. WIN	LDING IG	<del></del>	07/15/2	
NAME OF DI	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
		•		1	IAMI CIRCLE		
	IELD VILLAGE				I BEND, IN46614		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
		out her going to the	1				
		omes from when she was					
	first here. I know she is really sensitive						
		her arms and wrists"					
	Report "Conclus	ion: (Resident #G)					
	suffers from con	fusion. Statements from					
	staff are providir	ng nothing conclusive.					
	Her son seems to think that she is						
	repeating an old	idea"					
	A "Resident/Family Concern Report,"						
	dated 4/18/11 and signed by the DON,						
	indicated, "Concerning Resident #G						
		rn: This writer noted					
	_	down the hall in her					
	-	g pushed by (CNA #13), I					
	`	#G) how she was doing.					
	•	ery good right now.' Upon					
	_	ng she complained that					
		s complained that she was					
		hI questioned (CNA					
	, ·	NA in her room this					
	`	A #8) said 'I didn't say					
		ner to the bathroom."					
	_	(A (#8) that resident's					
	many times have	fferent reasons and that					
		nis. We merely take them					
	to the bathroom.	_					
		CNA apologized to					
	resident.	C1111 apologizou to					
	regident.						
	A letter to the Inc	diana State Denartment of					
		9/11, which included the					
		diana State Department of 0/11, which included the					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155684	B. WIN	IG		07/15/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	IAMI CIRCLE		
SOUTHE	TIELD VILLAGE			SOUTH	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	·	regarding CNA #8 and					
		on by Resident #B)					
		VA #8) was also involved					
		omplaint made by					
	· ·	(Resident #G). She					
		o CNA's complained that					
	she urinated too frequently. One of these						
	CNA's was (CNA #8)"						
	Resident #G's clinical record and the Personnel Record of CNA #8, lacked documentation that the 4/2/11 and the						
	_	nt of alleged abuse by					
	Resident #G was	reported to State					
	authorities. It wa	as briefly mentioned (21					
	days later) in the	above letter and incident					
	report, dated 5/9/	/11.					
		ent #G's clinical record					
		:00 A.M., indicated					
	diagnoses of, but	not limited to,					
	••	miparesis, and legally					
	blind. She was a	dmitted to the facility on					
	3/3/11 from an ac	cute hospital. A quarterly					
		Data Set) Assessment,					
	dated 6/31/11, in	dicated Resident #G's					
	vision was severe	ely impaired, was					
	occasionally inco	ontinent of urine and					
	needed limited as	ssistance of one for					
	toileting.						
	The Administrator indicated in an						
	interview on 4/14	4/11 at 4:00 P.M., she					
	was unaware of t	the abuse allegations.					

002662

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION  00	(X3) DATE S COMPL	ETED
		155684	B. WIN			07/15/2	011
NAME OF I	PROVIDER OR SUPPLIE	3		1	ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	FIELD VILLAGE				IAMI CIRCLE I BEND, IN46614		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	$\neg$	ID	DROUBERIG N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Nursing has always					
		issues. The previous					
	DON did the same thing."						
		1', 1' (',1 1 117) '					
		lity policy titled "Primary					
		on Policy," dated 9/2000,					
	1	y: It shall be the policy					
		llage that all residents of ree from verbal, sexual,					
	1						
	physical, and mental abuse, corporal punishment and involuntary seclusionPolicy/Procedure Definitions:1. Abuse: the willful infliction of injury,						
		nfinement, intimidation,					
		vith resulting physical					
	_	ental anguish. Also					
	includes, Depriv	ration by an individual,					
	including a care	taker, of goods or services					
	that are necessar	ry to attain or maintain					
	physical, mental	and psycho-social well					
	being. 2. Verbal	Abuse: The use of oral,					
	1	ed language that willfully					
		ging and derogatory terms					
		eir families, or within					
	_	tance(Examples:					
		saying things to frighten a					
	1	sical Abuse: Includes					
		, pinching, and kicking. It					
		ntrolling behavior through					
		nent. 5. Mental Abuse:					
	Includes, but is a	assment, threats of					
		eprivationNeglect:					
	1 -	le goods and services					
	Tanuic to provid	ic goods and services					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155684			(X2) MULTIPLE CC  A. BUILDING  B. WING	00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		6450 M	ADDRESS, CITY, STATE, ZIP CO IAMI CIRCLE I BEND, IN46614	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	anguish, or mentillnessAbuse-IofProcedure: 1 personnel will be potential for abu Administrator w monitoring quali improvement propatterns, occurre would be sugges within the facil will be responsibility incident/accident abuseInvestigated Staff incidents w neglect, are investigation. It facility to finalized 3-5 days"  The immediately with investigation. It facility to finalized 3-5 days"  The immediate journess of the investigation of the immediate on proper protocol abuse and neglect abuse policy and to be reasonable all management.	dentificationstaff and supervisory e cognizant of the se of residents2. The ill be responsible for ty assurance and quality ogress reports for nces and trends that tive of abuse, neglect, lity. 3. The Administrator ole for monitoring t reports for potential tionProcedure:3. chich involve abuse, vestigated as follows: 3.1				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155684		A. BUII	LDING	NSTRUCTION 00	(X3) DATE: COMPL 07/15/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  AMI CIRCLE BEND, IN46614	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	form to include a neglect, notified Director of the in posted phone nur Administrator an multiple location instructions to imallegation of abust the Administrator monitor abuse printerviewing five no less than six in facility will continued to reduce annually, bremained at the loof pattern, no act for more than minimmediate jeopar continued to recond and monitor staff to follow the corresponding to the co	e daily stand-up meeting llegations of abuse and the facility Medical amediate jeopardy, anbers of the d Director of Nursing in s of the facility with amediately report any se at any time, ensured a ror her designee will otocol by randomly residents per week for nonths, and ensured the nue to provide abuse and a upon hire and at least aut the noncompliance ower scope and severity ual harm with potential mimal harm that is not redy to ensure staff agnize and report abuse to ensure they continued rective action plan.					
F0490 SS=L	that enables it to u and efficiently to a	administered in a manner se its resources effectively ttain or maintain the highest al, mental, and psychosocial resident.					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155684 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6450 MIAMI CIRCLE SOUTHFIELD VILLAGE SOUTH BEND, IN46614 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on interview and record review, the F0490 F 490 07/18/2011 Administrative Staff failed to ensure Regarding Resident #B, CNA #8 was Residents in the facility were protected suspended on 5/4/11 after the facility from physical and verbal abuse by failing became aware of the allegation. The to follow their policy and procedures for CNA was terminated on 5/9/2011 following an investigation into the reporting, investigating, monitoring, and matter. This incident was reported to documenting related to failure to suspend ISDH on 5/3/11. accused staff, investigate and document abuse allegations, and monitor for Regarding Resident #D, the facility patterns and occurrences of alleged abuse has reviewed all grievances from this resident and/or family members and for 2 of 4 residents (Resident: #B, #D) in the facility alleges that this allegation the sample of 4 and 2 of 6 residents was never reported to any member of (Residents: #F, #G) in the supplemental administration at this facility. sample of 6. This deficient practice had Resident #D has since been the potential to affect all 60 of 60 discharged from the facility. Because the facility was not aware of residents residing in the facility. these allegations during her admission, an investigation into this The immediate jeopardy began on 7/05/11 alleged incident did not occur. when Resident # F, who was recovering from recent back surgery, reported to Regarding Resident #F, the resident did not report to the facility that she CNA #3 on 7/4/11 that CNA #2 had had been thrown into bed. This thrown her into bed and left her sideways allegation was not revealed to in the bed. Resident # F then reported the administration until the ISDH incident on 7/5/11 to the Director of complaint surveyor interviewed the Nursing who failed to suspend CNA #2 resident. As soon as the facility became aware of this allegation, and protect other residents from potential CNA #2 was immediately suspended harm during investigation of the alleged and an investigation was started. abuse. The Administrator and the Director CNA #2 was terminated on 7/19/11. of Nursing (DON) were notified of the The surveyor was aware of this immediate jeopardy at 5:30 P.M. on incident during the survey, and a follow-up report was sent to ISDH 7/13/11. The immediate jeopardy was: informing them of the facility's removed on 7/15/11, but noncompliance conclusion to the investigation on remained at the lower scope and severity 7/19/11. of pattern, no actual harm with potential

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6WFT11

Facility ID:

002662

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	155684	A. BUI	LDING	00	07/15/2	
		155064	B. WIN			07/15/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
COLITUE				1	IAMI CIRCLE		
	FIELD VILLAGE			SOUTH	BEND, IN46614		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		inimal harm that is not			Regarding Resident #G, CNA #	8 was	
	immediate jeopardy.				terminated on 5/9/11 and CNA #15		
					was terminated on 7/12/11.		
	Residents: #B, #	C, #D, #F, #G					
	Findings include:  1. A"Resident/Family Concern Report,"				Mandatory in-services began		
					immediately upon the facility		
					becoming aware of the immedia jeopardy citation on 7/13/11. A		
					staff members were educated be		
	dated 5/3/11, and signed by the Chaplain, indicated, "Nature of Concern: Resident (#B) reported rough handling and bad				the beginning of their next shift		
					the proper protocol to report ab		
					what types of things to report, a	nd	
	attitude of CNA #8 when resident asked				what to do if the report is not		
	repeatedly for bed pan last week. Resident #B thought she had asked 'someone in				followed up on. Staff members	were	
					instructed to notify the Administrator, or designee in the	ie.	
	ı	ve this CNA (#8) help			Administrator's absence,		
	1 ~	ast evening, 5/2/11, (CNA			immediately upon becoming aw	are	
		Resident #B's) shower.			of any abuse allegation. In-serv	vices	
	l '	ported she was sprayed in			for all staff were completed by		
	l ` ′ ′	NA #8) was not following			7/18/11. (Attachment A)		
	· ·	erning (Resident #B's)			Management and on-call nursin	σ	
	clothing"	(resident "2 5)			staff were in-serviced on 7/14/1		
	Ciounig				review proper protocol for repo	rting	
	An "Investigatio	n" report, dated 5/4/11			abuse. (Included in Attachment	t A)	
	1	N #9, indicated, "The			TTL - C - TIM - A 1 - T 1 - 4 - 4 - T	. 1	
		Jurse (LPN #10) had			The facility Administrator revie the facility's policies and proced		
	1 ^	OON re: (regarding) a			regarding abuse and neglect on	aures	
	· '	(Resident #B) and (CNA			7/13/11. They were found to be	e	
		(Resident #B) and (CNA (B) did not want (CNA			reasonable and accurate. Howe	ver,	
	. ' '	*			after further review, minor		
		I was working Wing 200			modifications were made to the		
	` ′	d overheard the phone			policy, "Abuse- Identification or Protection of the Resident" to	ı and	
		he nurses station on			simplify the language and the		
	Wed., April 27th	1."			procedure for staff members.		
					(Attachment B)		
	During interviev	w with the DON on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155684 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6450 MIAMI CIRCLE SOUTHFIELD VILLAGE SOUTH BEND, IN46614 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 7/12/11 at 2:30 P.M., she indicated she The facility Medical Director was was unaware Resident #B requested CNA notified of the immediate jeopardy #8 not be assigned to provide her care. citation on 7/14/11. Review of CNA's Personnel File on The phone numbers of the Administrator and Director of 7/11/11 at 3:20 P.M. lacked Nursing were posted in multiple documentation of an investigation, a State locations on 7/14/11 in order for any reportable, counseling, or disciplinary staff member to directly notify action regarding the issue reported by administration of any allegations of LPN #10 regarding Resident #B's abuse, at any time. accusation of alleged rough handling by The form used as a guide for CNA #8 when assisting her with the discussion in daily stand-up meeting bedpan (4/27/11). was revised on 7/14/11 to include the statement, "Allegations of abuse or 2. During interview with Resident #D's neglect?" (Attachment C) daughter on 7/11/11 at 2:15 P.M., she In order to ensure all staff are indicated her mother had told her that a educated on abuse and neglect on an night CNA cussed at her, threw her in ongoing basis, the facility will bed, and told her "I'm tired of you using continue to provide education on this that d--n call light. I'm tired of coming subject upon hire and at least twice annually. into your room. "My mother complained 'They're mean to me. They're mean to me.' In order to monitor and ensure that I, at first, thought my mother was abuse policies are followed, the imagining it, but when the bruises and Administrator or her designee, will tremors were evident, I went to the DON randomly interview five residents per week for a time period of no less with my concerns. I told her mother than six months as to how staff described the CNA as being a (race members have been treating them. stated), tall woman. The DON said, 'We Any concerns will be thoroughly don't have a tall (race stated) girl working investigated. (Attachment D) here.' My mother was lying in bed and Results of the monitoring program looking up at the individual which will be reviewed at the monthly CQI probably made her look tall." (Continuous Quality Improvement) meeting. Areas of non-compliance In a second interview with Resident #D's

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CORRECTION	155684		LDING	00	07/15/2011	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 077 10720 11	
NAME OF I	PROVIDER OR SUPPLIER			1	IIAMI CIRCLE		
SOUTHF	IELD VILLAGE			1	BEND, IN46614		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)	-
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	daughter on 7/12	/11 at 9:20 A.M., she			will be addressed immediately		
	indicated she ask	ed her mother if she			A11		
	could remember	the name of the CNA			Alleged date of compliance is 7/18/2011.		
	who was rough v	vith her. "It was a (race			7/10/2011.		
	stated) girl in the	middle of the night."					
	"She did complai	in to the DON (Name)					
	about the treatme	ent. We were very upset					
	when the bruises	were discovered at the					
	hospital. Mother	remembers them shoving					
	her around and slamming her into bed and						
	she told them, 'B	e careful your going to					
	break my hip, again.' "						
	During interview	with the DON on					
	7/12/11 at 10:35	A.M., she indicated she					
	was able to valid	ate with the resident that					
	the CNA was jus	t hurrying. She further					
	indicated, as a re	sult, she did not feel					
	there was a need	to do a State Reportable.					
		20 1 1 1 2 1					
		f schedule was reviewed					
		VA #15 was the only (race					
	·	provided care to					
		he night shift. The May					
	· ·	chedules indicated CNA					
		provide care to Resident					
		ring dates: 5/24, 5/31, 6/7,					
	6/14, 6/18, and 6	/19/11.					
	CNA #15's Dargo	onnel File was reviewed					
		5 P.M. and lacked					
	documentation of						
		arding Resident #D or					
	ner ranning's affeg	ged abuse by CNA #15.					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155684	A. BUI	A. BUILDING 00 COMPLETED 07/15/2011			
		133004	B. WIN			01/13/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	IELD VILLAGE			1	IAMI CIRCLE I BEND, IN46614		
_		TATEMENT OF DEFICIENCIES		ID			(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	3. During intervi	ew with Resident #F on					
	_	.M., she indicated that					
		go, CNA #2 came into her					
	_	r to the bathroom. CNA					
		tting Resident #F's					
	_	hile she was sitting down.					
		CNA #2 that Physical					
		her she should be					
	standing when the brace is put on her. CNA #2 responded, "I'll do it my way."						
	Resident #F let her put the brace on while						
		ne was desperate to get to					
	_	hen she finished in the					
		#2 assisted her to her bed.					
		in, confronted CNA #2,					
		ng the position of the side					
	_	Resident #F informed					
		rsical Therapist #6 taught					
	_	d with the side rail down					
	so she could posi	tion her body up higher					
	-	CNA #2 replied in a					
		I'm not the therapist."					
		cated she was sitting on					
		d when CNA #2 grabbed					
		and pulled her down					
	toward the foot o	of the bed. "She then					
	pushed my shoul	ders down on the bed,					
		from my w/c onto the					
	-	sheet I used to cover my					
	_	here. When she got angry					
	* '	d as an apple. I was					
	afraid my back w	ould get injured. I just					
	had surgery and l	I don't want to have gone					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6WFT11 Facility ID:

ty ID: 002662

If continuation sheet

Page 66 of 74

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		STREET A 6450 M	ADDRESS, CITY, STATE, ZIP C IAMI CIRCLE I BEND, IN46614	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	beginning to recondicated she could her, but when she her room she was to offer assistance what happened to CNA #2 had donindicated CNA # condition which lift, but together up in the bed. "S queried about the Resident #F was indicated she was a Resident #F indiprovided her care isn't near me, but didn't have to see indicated she told (DON) the next of how she had frighthe DON was she never had any prothe past. "She told be assigned to talk further indicated filed a report the ramifications as a signed to the remaining the conditions as a signed when the conditions are conditions as a signed to the ramifications are signed to the ramifications as a signed to the ramifications are signed to the ramification as a signed to the ramification as a signed to the ramification as a signed t	restricted her ability to they managed to get her he rescued me." When e incident and what feeling at the time, she is fearful of CNA #2. Icated CNA #2 no longer ee, "I feel better that she is I would feel better if I ee her." Resident #F did the Director of Nursing day about CNA #2 and hend her. She indicated bocked and stated she had oblems with CNA #2 in did me CNA #2 would not ke care of me again." She the DON told her if she re could be legal a result.				
	7/13/11 at 11:00 suspended CNA	ted in an interview on A.M. that she had not #2 because Resident #F to her that CNA #2 threw				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684		(X2) MI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 07/15/2	ETED	
	PROVIDER OR SUPPLIEF		<u> </u>	6450 MI	IDDRESS, CITY, STATE, ZIP CODE IAMI CIRCLE BEND, IN46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	her into bed, but put her into the bed hanging off the belater, when I sout #F told me her for she used her food The DON further one of her best with the presence of the pres	that she was bossy and bed and left her feet bed. "Forty-five minutes ght clarification, Resident bet were on the bed and it to get her call light." In indicated CNA #2 was workers.  The conversation on P.M. with CNA #3, while of the DON and with the on, CNA #3 indicated ent #F sideways in her indicated Resident #F "threw her into bed and NA #3 and LPN #7 failed dent to the DON, but voiced mistreatment to mical record lacked f an investigation, a State					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A PUBLICATION (X3) DATE SURVEY  COMPLETED				
ANDILAN	of correction	155684	A. BUII			07/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				IAMI CIRCLE		
SOUTHF	FIELD VILLAGE				BEND, IN46614		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		as yelling 'Ever since					
	1 *	e catheter you've been a					
	1 -	someone knocks, I jump. sorry, but I couldn't help					
		is need comes up (to use					
	1 *	get frightened. Recently, I					
		but no one came. I hurt					
		sure was so great. I took					
		•					
	my blanket and folded it into a square and tucked it under me so I could pee on						
		g the rest of my bed wet.					
		(Social Service Staff #5)					
	and the DON.	(0.000					
	Review of an "In	ternal Investigation"					
		5/11, indicated, "Date of					
	Occurrence: 4/2	/11? or 4/3/11 Saturday					
	night. Description	on of Occurrence:					
	(Resident #G) c/o	o (complained of) a staff					
	member complai	ning that she wants to go					
	to the bathroom	a lot and that her hands					
	hurt after she gra	bbed her by the hands to					
		bathroom" A "Resident					
	1 *	t, dated 4/4/11, indicated,					
		ve vision and I can seeI					
		ng the night or late					
		all about me having to go					
		This person was saying					
	1	to the bathroom all of the					
		a time when I was. She					
	_	lem. She was angry kind					
		need to do something					
	I -	ds are tender and she					
	took me by the h	ands to take into the					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684	(X2) MUI A. BUILE B. WING		NSTRUCTION  00	(X3) DATE: COMPL 07/15/2	ETED
	PROVIDER OR SUPPLIER		B. WING	6450 MI	DDRESS, CITY, STATE, ZIP CODE AMI CIRCLE BEND, IN46614		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ	(X5) COMPLETION
TAG	bathroom. They	are sore"		TAG	DEFICIENCY)		DATE
	indicated, "At 12 (Resident #G) be incident that she Attempted to classhe was unsure. information to cate call Supervisor. called LPN #12 (DON (Name) and statement and both asked to tell what Resident (#G) discall light, but sor #G) said yelling statement content remembers. "You anyone I know." needed to go to this is all about good grabbed her hand her around. "You about your bladd bladder checked. wrong with you." "That may be truthe word 'forcefut talking throughous her face felt hot,	Resident (#G) said she he bathroom. "I know oing pee"Someone ls and was rough moving a need to do something er. You need to get your There is something ' Resident (#G) replied, e. (Resident #G) used 1.' The person kept at the event to the eck. (Resident #G) said and she was shaking all er hands hurt when they					

NAME OF PROVIDER OR SUPPLIER  SOUTHFIELD VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and wrists" Report "Conclusion: (Resident	STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<u> </u>	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED		
SOUTHFIELD VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and			155684	B. WIN			07/15/2	011
SOUTH BEND, IN46614  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and   SOUTH BEND, IN46614  ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and	NAME OF I	PROVIDER OR SUPPLIEF	<b>\</b>		1			
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  The "Internal Investigation" further indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and								
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indicated Resident G's son made the statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and		The "Internal In	vastigation" further					
statement, "I think this story about someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and			•					
someone complaining about her going to the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and								
the bathroom a lot comes from when she was first here. I know she is really sensitive when it comes to her arms and			<u>-</u>					
was first here. I know she is really sensitive when it comes to her arms and		1						
sensitive when it comes to her arms and								
			•					
wrists Report Conclusion. (Resident								
HC) and Company and Company Company		1						
#G) suffers from confusion. Statements		from staff are providing nothing						
		, , ,						
		conclusive. Her son seems to think that						
she is repeating an old idea"		sne is repeating a	an oid idea"					
A "Resident/Family Concern Report,"		A "Resident/Fam	nily Concern Report."					
dated 4/18/11 and signed by the DON,			•					
indicated, "Concerning Resident #G			•					
Nature of Concern: This writer noted		· ·	•					
resident coming down the hall in her								
wheelchair being pushed by (CNA #13), I		· ·						
asked (Resident #G) how she was doing.								
She said, 'Not very good right now.' Upon		`	,					
further questioning she complained that		· ·						
one of the CNA's complained that she was		1 ^	•					
'peeing' too muchI questioned (CNA			•					
#8), the other CNA in her room this			-					
afternoon. (CNA #8) said 'I didn't say		· * *						
that, I just took her to the bathroom."		`	•					
Explained to CNA (#8) that resident's		1						
many times have (sic) to urinate								
frequently for different reasons and that								
we can't judge this. We merely take them		1 1						
to the bathroomResolution and		1						
Disposition: "CNA apologized to								

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155684	A. BUI	LDING	00	COMPL <b>07/15/2</b>	
		133004	B. WIN			07/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SOUTHF	IELD VILLAGE			1	I BEND, IN46614		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	resident.						
	A letter to the Inc	diana State Department of					
	Health, dated 5/9	/11, which included the					
	Incident Report (	regarding CNA #8 and					
	another accusation	on by Resident #B)					
	indicated, "(CN	NA #8) was also involved					
	on 4/18/11 in a c	omplaint made by					
	another resident, (Resident #G). She						
	indicated that two CNA's complained that she urinated too frequently. One of these CNA's was (CNA #8)"						
		nical record and the					
		CNA #8, lacked					
		nat the $4/2/11$ and the					
	•	nt of alleged abuse by					
		e reported to State					
	authorities.						
	During on interni	iow with the					
	During an intervi	4/14/11 at 4:00 P.M.,					
		was unaware of the					
		s. "The Director of					
		ays addressed those					
	_	ous DON did the same					
	thing."	ous Dorvard the same					
	<u>5</u> .						
	Review of a facil	lity policy titled "Primary					
		n Policy," dated 9/2000,					
		y: It shall be the policy					
		lage that all residents of					
		ree from verbal, sexual,					
	_	ntal abuse, corporal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155684	B. WING		07/15/2011
	PROVIDER OR SUPPLIER FIELD VILLAGE		6450 M	ADDRESS, CITY, STATE, ZIP CODE IIAMI CIRCLE I BEND, IN46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	responsible for massurance and quarter progress reports and trends that was abuse, neglect, The Administrate monitoring incide potential abuseInvestigated Staff incidents was neglect, are investigation. It facility to finalized 3-5 days"  The immediately with investigation. It facility to finalized 3-5 days"  The immediate jett 7/5/11 was remort facility suspender alleged abuse and began immediated on proper protocolabuse and neglect abuse policy and to be reasonable all management staff to review proper protocolabuse, revised the form to include a neglect, notified	administrator will be nonitoring quality ality improvement for patterns, occurrences rould be suggestive of within the facility. 3. or will be responsible for ent/accident reports for tionProcedure:3. hich involve abuse, restigated as follows: 3.1 rr is suspended			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE S COMPLI 07/15/20	ETED
	PROVIDER OR SUPPLIER		STREET A 6450 M	ADDRESS, CITY, STATE, ZIP CODE IAMI CIRCLE I BEND, IN46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	multiple location instructions to in allegation of abuthe Administrato monitor abuse printerviewing five no less than six refacility will continued to reducation twice annually, be remained at the lof pattern, no act for more than minimmediate jeopa continued to record and monitor staff to follow the cordinal staff.	mbers of the dd Director of Nursing in as of the facility with amediately report any se at any time, ensured or or her designee will rotocol by randomly experience residents per week for months, and ensured the inue to provide abuse and an upon hire and at least out the noncompliance ower scope and severity much harm with potential mimal harm that is not redy to ensure staff or on the provide abuse of to ensure they continued rective action plan.				